



Review of Implementation of

# Community Needs

# Assessment Approach for Family Welfare in India



Policy Project II  
The Futures Group International



**Review of Implementation of**  
**Community Needs Assessment**  
**approach for Family Welfare in India**

**Policy Project II**  
**The Futures Group International**

# Contents

Foreword	v
Abbreviations	vii
Glossary of Indian Terms	ix
<b>Implementation of the Community Needs Assessment Approach in India</b>	<b>I</b>
<i>Gadde Narayana, Naveen Sangwan</i>	
<b>CNA Approach for Family Welfare in Andhra Pradesh</b>	<b>19</b>
<i>Gadde Narayana, A.Kameswara Rao</i>	
<b>CNA Approach for Family Welfare in Bihar</b>	<b>31</b>
<i>Daya Krishan Mangal, Gadde Narayana</i>	
<b>CNA Approach for Family Welfare in Gujarat</b>	<b>41</b>
<i>C.V.S. Prasad, Daya Krishan Mangal</i>	
<b>CNA Approach for Family Welfare in Karnataka</b>	<b>57</b>
<i>Ramakrishna Reddy, P.Hanumantharayappa, K.M.Sathyannarayana</i>	
<b>CNA Approach for Family Welfare in Madhya Pradesh</b>	<b>71</b>
<i>Ashok Das, K.M.Sathyannarayana</i>	
<b>CNA Approach for Family Welfare in Maharashtra</b>	<b>87</b>
<i>Sharad Narvekar, A.D.Pendse, K.M.Sathyannarayana</i>	
<b>CNA Approach for Family Welfare in Orissa</b>	<b>105</b>
<i>K.M.Sathyannarayana, Ranjana Kar</i>	
<b>CNA Approach for Family Welfare in Rajasthan</b>	<b>123</b>
<i>Hemant Dwivedi, Daya Kishan Mangal, Gadde Narayana</i>	
<b>CNA Approach for Family Welfare in Uttar Pradesh</b>	<b>133</b>
<i>J.S.Deepak</i>	



## Foreword

---

The nearly five years since India abolished its target system have been filled with both confusion and innovation. Confusion, because of the uncertain trumpet that prevailed at every level, and innovation, because states and districts have made sincere efforts to find new ways to deliver services under a broadened set of objectives. This volume traces the experiences of nine states in their overall programs and in their special trials. An excellent synthesis chapter comes first that details the tribulations since 1996 and reviews the nine state experiences.

This book is the successor to *Targets for Family Planning in India: An Analysis of Policy Change, Consequences, and Alternative Choices*, which appeared in 1998. Its first chapter traces the history of target setting and the consequences for the program, as well as the factors that led to the 1996 policy reversal. Other chapters present the experience of certain states in the first year or so of the transition.

The transition continues; it is by no means complete. The puzzles of how to blend enlarged objectives with softened work rules, during a flow of top down directives that often conflict with each other, have yet to be entirely resolved. In one sense the ambiguities will never be resolved in such a complex and far flung set of programs, but the major adaptations are likely to settle down after a few more years. A mosaic of program variations now exists, each one in flux and moving toward something new. This evolution must continue, not to a perfect end point but toward a system whose principle features lack the old rigid targets and one that has widened its aims.

While some sympathy with the old system persists and the targets in some form have not died easily, a few profound changes have occurred that seem irreversible:

- The old worker-specific, method-specific, and month-specific quotas are largely out of favour and gone.
- The rhetoric of the field-the vocabulary of discourse-has been largely transformed, to speak of the felt needs of the people, community interests, and multiple services.
- Truly major changes have been made to move toward new work rules, toward other methods to accompany sterilization, and toward other services than just contraception.



These changes are necessarily embraced within an administrative structure that continues much as before. The line from Delhi, with its large share of total funding and its central directives, down through the state managers and the districts, will not go away.

Moreover workers cannot simply be sent out to do good by their own lights and their own motivations. The context now is an admixture of the new ideology with the inevitability of top down budgets, staff allocations, and overall goals. Much of the enduring confusion in these five years arises from that tension-how to forge a field program that allows for worker judgment, community power, and local options, while simultaneously showing real achievements for urgent national goals.

The nine state reviews in this volume show what is needed from the research side: a ceaseless examination of experience from the general program and from trails of program variations. Each review broadly examines the reproductive health program in the whole state, describes creative projects there, and traces the transition toward a target-free approach that is adapted to local conditions, while still setting achievement expectations at the grassroots level. If reviews like those in this volume had not been done they would have been most urgently needed, and it is vital that they be continued on a regular basis.

The present review is offered with appreciation to Victor Barbiero, Director of the Population, Health, and Nutrition Office, and to Sheena Chhabra, Team Leader of the PREM Division, both of USAID in India, for their encouragement and support. Partial financial support was provided by the Rockefeller Foundation, which is gratefully acknowledged.

Reproductive behaviour has changed over most of India since the national program began 50 years ago, and the program, with all of its problems, deserves a generous share of credit. By 1992 fertility had fallen much below its traditional level: nine of the 15 largest states had crude birth rates in the 20s and had total fertility rates below three. The national averages were 29 and 3.4, and by the 1998-99 survey 48% of couples were using contraception. Yet replacement fertility is a good way off, and state programs will emerge only gradually that strike the right balance between operational effectiveness and sensitivity to the persons they serve. That process will be informed and advanced by studies like the ones provided in this volume.

John A. Ross  
Senior Fellow  
The Futures Group International



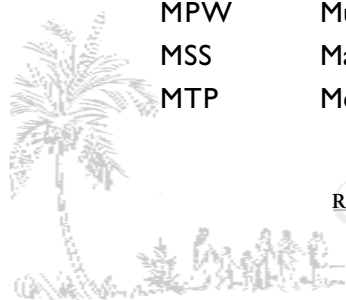
## Abbreviations

---

AD	Additional Director
AGTP	Awareness-Generation Training Programme
AIDS	Acquired Immuno Deficiency Syndrome
AN	Antenatal
ANC	Antenatal care
ANM	Auxiliary nurse midwife
ANMTC	ANM training centre
AVSC	Association for Voluntary Surgical Contraception
ARI	Acute respiratory infection
AWW	Anganwadi Worker
CBD	Community-based distribution
CBR	Crude Birth Rate
CC	Condom
CDMO	Chief district medical officer
CDR	Crude Death Rate
CEO	Chief executive officer
CHC	Community health centre
CMIE	Centre for Monitoring Indian Economy
CMHO	Chief medical and Health Officer
CMO	Chief Medical Officer
CMS	Chief Medical Superintendent
CNA	Community needs assessment
CPR	Couple Protection Rate
CSSM	Child survival and safe motherhood
Cu-T	Copper-T
DAP	District action plan
DDMHO	Deputy District Medical and Health Officer
DHFWO	District Health and Family Welfare Officer
DMHO	District Medical and Health Officer
DIFPSA	District Innovations in Family Planning Services Agency
DIO	District Immunization Officer
DPC	District Planning Committee
DPT	Diphtheria Pertussis Tetanus
DUDA	District Urban Development Agency



EC	Eligible Couple	NACO	National AIDS Control Organization
ECR	Eligible Couple Register	NFHS	National Family Health Survey
ELA	Expected Level of Achievement	NGO	Non-governmental organization
FRU	First Referral Unit	NIC	National Informatics Centre
FW	Family Welfare	NID	National Immunization Days
FWHC	Family Welfare Health Centre	NIHFW	National Institute of Health and Family Welfare
GOO	Government of Orissa		
GOI	Government of India	NSS	National Swayam Sevika
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit ...	OR	Operations research
		ORS	Oral rehydration salts
HDI	Human Development Index	ORT	Oral rehydration therapy
HMIS	Health Management Information Systems	PBA	Pregnancy-based approach
ICDS	Integrated Child Development Services	PHC	Primary health centre
IEC	Information, education, and communication	PLA	Participatory Learning for Action
IFA	Iron and folic acid	POL	Petrol, oil, and lubricants
IFPS	Innovations in Family Planning Services	PRC	Population Resource Centre
IMA	Indian Medical Association	PRI	Panchayati raj institution
IMR	Infant mortality rate	PSM	Preventive & Social Medicine
IPD	Integrated Population and Development	PVO	Private voluntary organization
IPP	Indian Population Project	RCH	Reproductive and child health
ISM	Indigenous Indian System of Medicine	RH	Reproductive Health
ITPD	Integrated Tribal Development Programme	RMP	Rural Medical Practitioner
IUCD/IUD	Intrauterine Contraceptive Device/ Intrauterine Device	Rs.	Rupees
KFW	Kreditanstalt für Wiederaufbau (KFW)	RTI	Reproductive tract infection
LHV	Lady Health Visitor	SC	Scheduled Caste
MCH	Maternal and child health	ST	Scheduled Tribe
MIM	Maternal and Infant Mortality	STD	Sexually transmitted diseases
MMR	Maternal Mortality Rate	SIFPSA	State Innovations for Family Planning Services Project Agency
MIS	Management Information Systems	SIHFW	State Institute of Health and Family Welfare
MO	Medical Officer	STI	Sexually transmitted infection
MHFW	Ministry of Health and Family Welfare	TBA	Traditional Birth Attendant
MPHA	Male-public Health Assistant	TFA	Target-free approach
MPW	Multi-purpose Worker	TFR	Total fertility rate
MSS	Mahila Swasthya Sangh	TT	Tetanus toxoid
MTP	Medical termination of pregnancy	UIP	Universal Immunization Programme
		UNFPA	United Nations Population Fund
		UNICEF	United Nations Children's Fund
		USAID	United States Agency for International Development
		WHO	World Health Organization





## Glossary of Indian Terms

Anganwadi	A village-level centre under the ICDS Programme
Bal Kalyan Samitis	Children Welfare Committees
Crore	1 crore = 1,00,00,000
Dai	Traditional midwife
Dudugi	Local announcement
Gram Pradhan	Village headman
Gram Sabhas	Village Committees
Jowar	Millet
Lakh	1 lakh = 1,00,000
Mahila Sammelan	Women's conference
Mahila Swasthya Sangh	Women's Health Group/Organization
Ma Raksha Mahotsava	Safe Motherhood Festival
Panchayati Raj	Body of local government at village level
Vanaspati ghee	Vegetable Oil
Tur	A type of pulse
Taluka	Territorial division below district
Pradhan/Gram Pradhan	Headman/Village Headman
Pucca	all-weather
Zilla Sarkar	District Planning Committee
Zilla Swasthya Samiti	District Health Committee



# Implementation of the Community Needs Assessment Approach in India



Gadde Narayana  
Naveen Sangwan

## Background

Since its inception in 1951, the Indian Family Planning Programme has undergone many changes to meet the varied challenges over the years. At different times, the programme has been expanded either to integrate services, as was done in the 1970s with the multi-purpose workers scheme. In recent years, in order to focus on the range of services critical for the health of women and children, the programme has been expanded to include elements of new schemes such as Child Survival and Safe Motherhood (CSSM), Universal Immunization, and Reproductive and Child Health (RCH).<sup>1</sup>

Prior to 1996, the programme used a target approach as the means to stabilize population growth. All services, planning, and financing were geared to achieving the demographic goals of reducing the birth rate and the rate of population growth. To achieve the long- and short-term demographic goals, this approach set targets in terms of a couple protection rate (CPR), which was further broken down into method-specific targets, with special focus on sterilization. The central government prescribed these targets annually for each state, which in turn passed the annual targets through the system down to the facility level.<sup>2</sup> Thus, achievement

<sup>1</sup> Leela Visaria, Shireen Jejeebhoy and Tom Merrick, "From Family Planning to Reproductive Health: Challenges Facing India" in *International Family Planning Perspectives*, January 25, 1999, p 844-49

<sup>2</sup> Gadde Narayana, Shalini Kakkar and Venkatesh Srinivasan, *Target Free Approach for Family Planning In India in The POLICY Project (ed) Targets for Family Planning in India: An Analysis of Policy Change, Consequences and Alternative Choices*, The Futures Group International, New Delhi, 1998



of contraceptive targets became the principal indicator of success for India's population stabilization effort. The target system placed little importance on clients' personal choices and did not encourage the use of a wider range of family planning methods. As the target system increasingly took its toll on services and quality, criticism grew as well. By the end of the 1980s, population experts, researchers, academicians, donors, and non-governmental women's groups in India had all registered strong objections to India's family planning programme.

In April 1996, the GOI introduced a major revision of its approach to family planning and primary health care. The MOHFW abolished method-specific family planning targets, and replaced it with what was initially called the TFA.

These factors, along with international developments during the 1994 International Conference on Population and Development and the 1996 International Women's Conference in Beijing, created a need for a change in approach.

In April 1996, the Government of India (GOI) introduced a major

revision of its approach to family planning and primary health care. The Ministry of Health and Family Welfare (MOHFW) abolished method-specific family planning targets, and replaced it with what was initially called the Target-Free Approach (TFA).<sup>3</sup> The main aim of the TFA was to shift the focus to clients' needs and to improve the quality of services. This paradigm shift called for planning to start at the basic facility level and to be based solely on identified client needs and intentions. Health workers would conduct surveys to ascertain these needs. In other words, the former "top-down" approach was to be replaced by a genuine "bottom-up" approach in which health workers' case loads would be determined by identified local needs. At the same time that targets were abolished, however,

MOHFW provided minimal guidance to the states on how to implement the new policy. As a result, in 1996 and 1997, most states lacked operational methodologies to assess community needs, develop realistic performance goals and plans, and institutionalize quality in service provision, especially at the district level and below. TFA at the operational level was even misinterpreted in some states as "no targets means no work." To avoid these unfortunate misconceptions and direct the programme more towards clients' needs, the new programme was recast into the "Community Needs Assessment" (CNA) approach in September 1997.<sup>4</sup> The underlying philosophy of the new approach, however, remained the same as the TFA.

## Objectives of the Paper

This paper synthesizes the results of nine case studies carried out by the POLICY Project in the states of Andhra Pradesh, Bihar, Gujarat, Karnataka, Madhya Pradesh, Maharashtra, Orissa, Rajasthan, and Uttar Pradesh. The objectives of the case studies were to:

- examine the transition from the original target system to the TFA and subsequently to CNA approach
- Analyze the countrywide implementation of CNA and the impact of the new system on programme performance
- Identify programmatic shortcomings that affected the transition, draw lessons from the experiences of implementation, and identify steps that could be taken to improve the management and performance of the new client-oriented system.

<sup>3</sup> Ministry of Health and Family Welfare, Manual on Community Needs Assessment Approach, Government of India, 1998

<sup>4</sup> Ministry of Health and Family Welfare, Manual on Community Needs Assessment Approach, Government of India, 1998



The case studies for nine states follow this synthesis chapter.

## Introduction of the Target-Free Approach

Starting in the 1960s, the Ministry of Health and Family Welfare annually fixed method-specific targets, which largely determined the character of programme implementation, monitoring, and evaluation at all levels. Over the years, this led to a situation where the achievement of contraceptive targets rather than client services became the major objective of public providers.<sup>5</sup> The obsession with targets and emphasis on sterilization resulted in poor coverage of younger and low-parity couples, virtual neglect of modern spacing methods, and inflated performance reports particularly for spacing methods. These conditions combined to severely limit the demographic impact of the programme. Not surprisingly, informed contraceptive choice, clients needs, and quality of services were inadequately addressed. The centralized planning and top-down target setting hindered management innovation and flexibility.<sup>6</sup> As a result, the overall reproductive health situation in India remained poor, and GOI found itself responding to performance shortfalls by periodically adjusting the timeframes for achieving programme objectives.

Population experts argued that focus on numerical targets thwarted attainment of the desired demographic impact and that excessive pressure to achieve targets resulted in over-reporting and mismanagement. Non-governmental Organizations (NGOs) and women's groups argued that the central government's notion that India's birth rate must be reduced by vigorous promotion of

contraception was a violation of human rights. The poor quality of care provided to women by service-providers was taken as a sign of how little regard those providers had for women's health. In the 1980s and early 1990s, several key stakeholders, including donor agencies, stimulated discussion of varied viewpoints and advocated for a shift from the target-oriented approach to innovative ways of meeting reproductive health needs using an integrated approach.

There was a growing interest in replacing the target system with an entirely different approach—one that would shift programme emphasis from providers to clients. In September 1995, GOI abolished targets in the states of Tamil Nadu and Kerala and requested every state to select one or two districts to test the TFA. The new approach envisaged decentralized planning at the sub-centre level, in consultation with the community, to determine annual workloads based on local needs. By shifting more explicitly to identified client needs and involving the community, the GOI also hoped to stimulate better quality services. Expected levels of achievement (ELA), instead of targets, were now to be set by workers at the grassroot level—female auxiliary nurse midwives (ANMs) and male multi-purpose workers (MPWs)—in response to community needs.

---

In the 1980s and early 1990s, several key stakeholders, including donor agencies, stimulated discussion of varied viewpoints and advocated for a shift from the TFA to innovative ways of meeting reproductive health needs using an integrated approach.

---

## Basic Characteristics of TFA

- Provide services according to client needs and eliminate centrally determined targets

<sup>5</sup> Gadde Narayana, Shalini Kakkar and Venkatesh Srinivasan, *Ibid*, TFGI, New Delhi, 1998

<sup>6</sup> Naveen Sangwan and Rishikesh M. Maru, "Target-Free Approach: An Overview" in *Journal of Health Management*, 1.1, 1999, p 71-96.



- Provide a wider choice of safe contraceptive methods and greatly strengthen and expand reproductive health services
- Emphasize the quality of services and decentralize programme planning and management to the district level and below
- Build partnerships with the community and make the programme a “people’s programme.”

### Change from TFA to CNA

In April 1996, without rigorously addressing the experiences gained by all the states in implementing the TFA, the central government decided to abolish targets throughout India, making the entire nation target free. Targets were removed without adequate preparation and without discussion of what would

To convey clearer guidelines to health workers and to simplify the implementation of the TFA concept and philosophy, the government renamed the TFA as the Community Need Assessment (CNA) approach.

replace the old system. No new monitoring system was proposed to replace the target system. At the policy level, the shift to the TFA was recognized as a necessary step for enhancement of the quality of services. At the implementation level (state and district), however, the only guidance programme implementers

received was in the form of a manual (written in English) to orient them on decentralized planning, starting at the sub-centre level.

In September 1997, the government realized that the TFA manual was not proving to be useful in implementing the new approach and that the term TFA was a misnomer. Many health workers equated TFA with “no work” or “no more monitoring based on targets” and became complacent. The formats introduced to estimate community needs and expected levels of achievement were too complex to be followed by the workers. The training provided to health workers in the use of these formats was inadequate and lacked uniformity. To convey clearer guidelines to health workers and to simplify the implementation of the TFA concept and philosophy, the government renamed the TFA as the Community Need Assessment (CNA) approach. In 1998, they developed and distributed a CNA manual to replace the TFA manual. Currently, the programme follows the CNA approach.

### Analysis of the Transition from Targets to CNA

Moving away from targets to the TFA is a major organizational change. Implementation of an organizational change of this kind in a vast bureaucratic system is a daunting task. The change process involves three stages: planning, implementation and stabilization. The main purpose of planning is to develop a strategy for implementation. It involves identifying critical implementation issues and designing operational strategies to implement the change.

Figure 1  
The Shift from Targets to CNA

	Target Approach		Community Needs Assessment Approach
Driving Force	Targets	→	Community needs
Orientation	Provider	→	Client
Concern	Target Achievement	→	Quality of care
Goal	Demographic impact	→	Reproductive health status
Approach	Top-down	→	Bottom-up



## Experiences of Implementing TFA/CNA

On a pilot basis in 1995–96, GOI designated a single district in 18 different states and two entire states as “target free.” The objective was to learn from experience and determine the feasibility of adopting the TFA nationwide. In the absence of guidelines, each state responded according to their level of comprehension of the new policy. For instance, Andhra Pradesh designed a very comprehensive information and monitoring system and was ready to test run the system in the target-free districts of East Godavari and Medak. The government of Rajasthan introduced a new innovative information and service delivery system in Dausa and Tonk districts. Uttar Pradesh carried out operations research in Agra and Sitapur districts. Tamil Nadu designed and introduced a new information system at all levels. Other states largely waited for further instructions from the central government.

The initiatives taken by the states are an indication of the recognition of the need to change or revamp the information and monitoring systems of the family welfare programme. GOI, without taking into account the changes contemplated or implemented and without a comprehensive review of experiences gained in the first phase of implementation of the TFA, imposed the TFA in all states in February 1996. Several states initially resisted the change and wanted the old target system to continue with some cosmetic changes. GOI responded to the situation by directly instructing District Collectors or District Magistrates to abolish targets and to introduce the target-free system with the help of centrally designed new formats. Guidelines and a budget to train workers and medical officers were given directly to district authorities. State-level Directorates of Health and Family Welfare were mere spectators to this process. The training was conducted without supervision, it was not of

uniform quality, and many did not understand the philosophy behind the new approach. The formats provided were complex and many workers could not understand how to calculate the ELAs based on sample surveys. Training programmes involving several hundred thousand workers throughout the country could not be completed until the end of 1997.

Family planning performance in most states declined from 1996 to 1997, creating a negative reaction, particularly among top-level managers who answer directly to their immediate political bosses. The decline in performance in traditionally high performance states was marginal, but in states like Uttar Pradesh and Bihar, it was sharp and perceptible. After several consultation meetings and workshops, GOI realized

the limitations of the TFA formats and manual and the negative effect of the term “target free.” The manual was subsequently revised, and in a meeting held for representatives of state governments in September 1997, in New Delhi, the revised manual was approved

at the same time as the name of the approach changed. In many states with weak monitoring systems, the workers stopped visiting villages to provide services and expected villagers to visit clinics that were located far away with no transport facility. The term CNA was chosen to convey the message that the workers’ responsibility is to assess the needs of the community and provide services as per the community needs. A senior GOI officer, reflecting on the prevailing situation, stipulated, “We may have adopted a target-free approach, but this is with reference to numerical method-specific targets. We are not in a goal-free situation. We still

In many states with weak monitoring systems, the workers stopped visiting villages to provide services and expected villagers to visit clinics that were located far away with no transport facility.



have our goals and objectives intact, and this needs to be emphasized.”<sup>7</sup>

The CNA approach has modified formats for data collection. The number of formats was reduced from 14 planning and reporting formats for the TFA to nine formats for the CNA approach. GOI dispatched the English version of the CNA manual and formats to state governments in 1998, necessitating reorientation of workers. In addition, GOI instructions were not clear on whether the new formats should replace the old ones or continue as a parallel activity. Training of workers remained a major issue. A uniform training programme was designed to cover all workers in the country without taking into account differences in capabilities

and skills, which turned out to be a major obstacle to institutionalizing the new system. In many states, the printed formats for CNA were not made available. Implementation of the CNA approach was not uniform, varying from district to district within a state as well as from state to state. Given this scenario, states responded to the new system in different ways. Some states have blended the old

approach with the new approach and designed new monitoring systems. Some have tried to implement the new system, completely replacing the old system. A few others have neither the old nor the new system in place. The TFA, however, succeeded in

making the lexicon, and the use of such terms as ‘quality of services’, ‘community or client needs’, ‘integrated approaches’, and ‘expected levels of performance’ are used to reflect the new philosophy of service delivery. The following sections of this paper summarize the experience of nine states in adopting the new system.

## Andhra Pradesh

In the first phase of the TFA, Andhra Pradesh abolished targets in East Godavari and Medak districts. Even before selecting these districts for the TFA, the Directorate of Family Welfare designed a new information and monitoring system to completely replace the old system. TFA districts were selected to pretest the new system. This process was discontinued, however, after an enthusiastic beginning due to lack of support from the central government.<sup>8</sup> The performance in both TFA districts declined considerably. Many at the state level thought that the new approach would present a major hurdle to achieving the state’s demographic objectives. With strong political backing available to the state’s programme, the Department of Health and Family Welfare initiated the formulation of a comprehensive state population policy that included both demographic and RH goals.<sup>9</sup> The legislature approved the state population policy, the first of its kind in the country, in 1997. In the mean-time, the state completed CNA training at all levels. The workers generate expected levels of performance after conducting surveys, and these numbers are compiled at various levels to arrive at expected levels of performance

In Andhra Pradesh, with strong political backing available to the state’s programme, the Department of Health and Family Welfare initiated the formulation of a comprehensive state population policy that included both demographic and RH goals.

<sup>7</sup> Department of Health and Family Welfare, Government of Madhya Pradesh and IIHMR, Proceedings of the Workshop on Population Policy for Madhya Pradesh: Identification of Issues and Challenges, The POLICY Project, The Futures Group International, 1999

<sup>8</sup> C.B.S. Venkata Ramana, “Target-Free Approach for Family Welfare: A Review of Experiences in Andhra Pradesh”, in The POLICY Project (ed) Targets for Family Planning in India: An Analysis of Policy Change, Consequences and Alternative Choices, The Futures Group International, New Delhi, 1998, p 26-47.

<sup>9</sup> Government of Andhra Pradesh, Andhra Pradesh State Population Policy: A Statement and A Strategy, 1997



at the district and state levels. At the end of this exercise, in their meetings with district officers, state officers compare the policy objectives and the ELAs arrived at based on data collected from below.<sup>10</sup> After considerable discussion and negotiation, the district and state officers reach a consensus on the ELA for the year. The districts, in turn, distribute these numbers to all health institutions in the district. Performance monitoring systems at both the political and administrative levels in the state were strengthened, and additional resources were provided to districts to achieve results. Consequently, performance, particularly sterilization performance, has significantly improved while spacing method use has remained more or less the same over the same period of time. Senior administrators of Andhra Pradesh strongly believe that the state government, given its structures and systems, has no capacity to serve spacing method users. So the programme strategy places major emphasis on the public sector for sterilization services and on the private sector for marketing of spacing methods. Recently, the state government has promoted male sterilization. An experimental project conducted to promote male sterilization in two districts was a major success, with the number of male sterilizations conducted in a year exceeding that of female sterilizations. According to the results of National Family Health Survey II (NFHS II), Andhra Pradesh's achievements are especially significant in family planning acceptance, immunization coverage, and maternal health care services—particularly antenatal care (ANC) and institutional deliveries.<sup>11</sup> Having achieved replacement level fertility, Andhra Pradesh now intends to concentrate its efforts on reducing infant mortality and increasing age at marriage. Many state

administrators feel that they have a successful model for others to follow.

## Bihar

Bihar is one of India's large states with low contraceptive prevalence and high fertility. Its performance in regard to deliveries assisted by trained providers and immunization coverage of children is also a cause for concern. The Department of Family Welfare introduced the TFA in one of the relatively better performing districts in 1995–96. The department reviewed the experiences in implementing TFA in this district with the help of an external agency. Even before discussing the issues involved, GOI mandated introduction of the TFA in the entire state. The state government stopped providing targets and discontinued monthly performance review meetings at all levels. The department could not train workers in the use of the new formats, since many in the department did not comprehend the content of the manuals themselves. In 1998, two years after introduction of the TFA, a donor agency helped the state initiate the training of workers. Even after training, few workers are in a position to use the new formats. No annual surveys are conducted to determine the ELA based on community needs assessment. ELA are generated in the beginning of each year based on the past year's performance or based on workers' perceptions. Many of the medical officers in the state considered the TFA as the "tension-free approach" because there was no need for accountability after the introduction

---

Many of the medical officers in the state considered the TFA as the "tension-free approach" because there was no need for accountability after the introduction of the new system.

---

<sup>10</sup> Gadde Narayana and A. Kameshwara Rao, Community Needs Assessment Approach in Andhra Pradesh, The POLICY Project, The Futures Group International, New Delhi, 1999 (Mimeo)

<sup>11</sup> International Institute for Population Sciences, Andhra Pradesh: National Family Health Survey-India, 1998-99, Bombay, 2000.





of the new system.<sup>12</sup> Performance of all methods, particularly sterilization, sharply declined in 1996–97 and remained low after that. Many in the department felt that there was a perceptible improvement in the quality of services offered after introduction of the TFA, in terms of method acceptance among low-parity and young couples. However, there is no evidence to support this assertion, and, therefore, it looks more like a justification for poor performance. More intensive efforts are required to build capacity and to improve programme management to make the CNA approach a success in the state.

## Gujarat

The government of Gujarat introduced the TFA in Valsad district in 1995–96. The workers were briefed

The TFA was introduced in all districts in April 1996 but only in November 1997 did the state receive clear guidelines from the central government on how to implement the new approach.

about the TFA and asked to improve the quality of services. In the initial months, due to lack of any guidelines about the new approach, the performance of the district declined drastically, sending panic signals to the administration. Several review meetings with Primary Health Centre (PHC) medical officers and workers occurred that

emphasized the need for regularly updating registers of workers to serve the community. Due to these intensive efforts, method-specific performance at the end of the year was only 17–20 per cent less than what it was in the previous year. The TFA was introduced in all districts in April 1996 but only in November 1997 did the state receive clear guidelines from the central government on how to implement

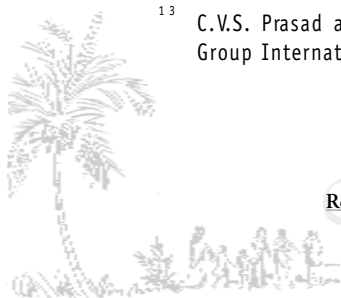
the new approach. The Health and Family Welfare Department trained 2,422 medical officers and 16,890 workers by March 1998. Workers then carried out a community-level survey with the help of formats given to them and estimated the expected levels of performance. Following this process, the estimated workloads were unrealistically high in a large number of districts and low in others. The Directorate advised the districts to take past performance as a benchmark and compare past performance with the estimated expected levels of performance. In Gujarat, workers prepare sub-centre plans based on surveys but these numbers are scaled down or up based on past performance.<sup>13</sup> In general, reported performance declined slightly in 1996–97 for all family planning methods and subsequently remained stagnant at that level. Monitoring of family planning performance is now based on ELA. In addition, the state has indicators to monitor quality of services. State officials were not perturbed by the marginal decline in performance and were confident that the new system would be fully institutionalized within a couple of years and start yielding results.

## Karnataka

Based on instructions received from GOI in 1995, the government of Karnataka selected Mandya district to experiment with TFA. Mandya district officers passed on the information to the PHCs and workers. There was no decline in year-end performance. One of the medical officers of Mandya observed, “Performance in the district remained more or less the same even without targets because workers in this district do not have to make much effort. People accept family planning on their own. In such a situation, targets or lack of

<sup>12</sup> D. K. Mangal and Gadde Narayana, *The Target-Free Approach in Bihar: A Review of Experiences*, The POLICY Project, The Futures Group International, New Delhi, 2000 (Mimeo)

<sup>13</sup> C.V.S. Prasad and D. K. Mangal, *The Community Needs Assessment Approach in Gujarat*, The POLICY Project, The Futures Group International, New Delhi, 2000 (Mimeo)



them make no difference”.<sup>14</sup> With the introduction of TFA in 1996, the state made substantial changes to the government-prescribed formats. Workers conducted annual surveys with the help of the eligible couple registers (ECRs), but this data remained unutilized because the targets were prescribed from the top. After the TFA was mandated, the state realized the need to use these data and the centrally prescribed coverage norms to arrive at ELA at all levels. However, the centrally prescribed formats were not useful for calculating the expected levels of achievement for family planning methods. The state directorate, therefore, instructed districts to take past performance into account to arrive at ELA for family planning methods. Some districts considered the past year’s performance and others took a three-year average of past performance levels to arrive at the expected level of achievement for family planning. Karnataka also conducted training programmes to reorient health workers as well as members of Panchayati Raj Institutions (PRIs) and anganwadi workers (AWWs). In fact, implementation of the new system preceded the training programmes. In general, workers, supervisors, and medical officers welcomed the new approach and adhered to all instructions provided in terms of training programmes, use of survey formats, and preparation of sub-centre-level workplans. However, many felt that the new approach has not addressed and is not helpful for addressing the tremendous variations within the state. Absence of such differentiated approaches makes micro-level planning a theoretical rather than a practical exercise. The state needs to develop different formulae for different regions or districts to estimate expected levels of performance. Sterilization performance in the state improved slightly after introduction

of TFA. Reported performance on all spacing methods showed a decline of 5-10 per cent after 1996–97.

## Madhya Pradesh

Madhya Pradesh was one of the first states to conduct elections to local bodies after the 73<sup>rd</sup> and 74<sup>th</sup> amendment to the Constitution of India and devolved significant authority and responsibility to the elected bodies. The elected bodies became responsible for implementation of PHC and family welfare programmes, and all health workers were transferred to PRIs. As a result of structural changes in programme implementation, the previously major role of Department of Health and Family Welfare became marginal. At the same time, elected representatives of PRIs had little knowledge of programmes and lacked the skills and experience to govern. It is in this milieu that the TFA was first introduced in Narsinghpur district. Workers were asked to conduct an eligible couple (EC) survey and set their own targets in order to improve performance. The family planning performance of the district dropped substantially in 1995–96. After introduction of TFA in the entire state, workers were instructed to follow the GOI guidelines, conduct eligible couple (EC) surveys, and set their own ELA based on past performance. The state completed the training of district officers in 1997–98. Since workers did not receive any training during the two-year period in which TFA was implemented, the methodology followed to calculate expected levels of achievement varied

---

Madhya Pradesh was one of the first states to conduct elections to local bodies after the 73<sup>rd</sup> and 74<sup>th</sup> amendment to the Constitution of India and devolved significant authority and responsibility to the elected bodies.

---

<sup>14</sup> P. Ramakrishna Reddy, P. Hanumantharaya and K. M. Sathyanarayana, The Community Needs Assessment Approach in Karnataka, The POLICY Project, The Futures Group International, New Delhi, 2000 (Mimeo)



from one institution to another.<sup>15</sup> Information collected with the help of ECRs designed a few years prior to the introduction of the TFA was not sufficient to prepare micro-plans. Realizing this and to be in tune with the requirements of the TFA formats, the Madhya Pradesh government completely modified the ECRs and made newly printed registers available to all sub-centres. ANMs collected the information but were not in a position to process the information to identify unmet need for family planning and RH services. Instead of training ANMs, this responsibility was entrusted to statistical officers at the PHC level. There was no involvement of PRIs in the assessment of community needs. The state government has, however, prepared a blueprint for training elected representatives about their roles and responsibilities.

Political commitment to the family welfare programme in Madhya Pradesh is very high, and the department is trying to implement mechanisms to continuously evaluate performance and review strategies for achieving policy objectives.

The Madhya Pradesh government formulated a state population policy in January 2000, that clearly spells out its family planning and RH objectives for the next decade.<sup>16</sup> Integrated approaches involving elected representatives of local bodies are essential for achieving these objectives. Family planning performance in the state declined considerably for all

methods except for oral contraceptives. Political commitment to the family welfare programme in Madhya Pradesh is very high, and the department is trying to implement mechanisms to continuously evaluate performance and review strategies for achieving policy objectives.

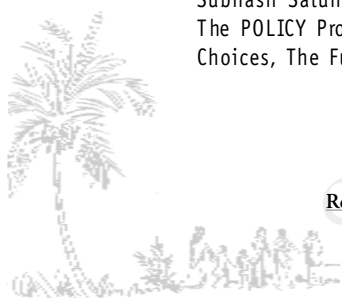
## Maharashtra

Maharashtra selected Satara and Wardha districts in 1995–96 to abolish targets. Satara district officials prepared a district action plan that emphasized the need for a maternal child health (MCH) approach for family planning. Satara district implemented its plan after conducting a baseline survey in the district with the help of health workers. Wardha has not made any attempt to prepare a plan. In 1996–97, TFA was extended to all districts. After review of the TFA manual provided by GOI, the Directorate of Family Welfare modified the formats to suit local conditions and termed the new approach “self-determination of targets.”<sup>17</sup> The quality of training varied by district, and community involvement was negligible. More systematic efforts were made to train workers on the CNA approach in 1997–98. In addition to the material provided by the central government, the Directorate introduced four data collection formats to be used by sub-centre functionaries to assess community knowledge and to estimate ELA for Family Planning/RH services. By March 1998, all health functionaries in the state were trained in the CNA approach. Training programmes were evaluated and strengths and weaknesses identified. However, the implementation of the CNA approach was beset with several problems. The formats designed required several modifications to capture the relevant information. While the need to modify the formats was recognized, additional resources necessary to make the modifications were not available. Since the attempts to prepare micro-plans were not successful, the government of Maharashtra decided to use the findings of each district’s RCH survey to prepare district-level plans.

<sup>15</sup> Ashok Das and K. M. Sathyanarayana, *The Community Needs Assessment Approach for Family Welfare in Madhya Pradesh*, The POLICY Project, The Futures Group International, New Delhi, 2000 (Mimeo)

<sup>16</sup> Government of Madhya Pradesh, *Madhya Pradesh Population Policy*, January 2000

<sup>17</sup> Subhash Salunke and Sharad Narvekar, *Target Free Approach for Family Welfare: A Review of Experiences in Maharashtra*, in The POLICY Project (ed) *Targets for Family Planning in India: An Analysis of Policy Change, Consequences and Alternative Choices*, The Futures Group International, New Delhi, 1998, p 49-78



The draft plans prepared by the district officers required several modifications and refinements, which were never made. During this period, family planning performance declined considerably, but MCH services improved to a large extent. Maharashtra has long been considered as a state with clear vision for implementing innovative strategies to achieve results. Several other states, particularly in the south, have recently shown better performance than Maharashtra, however. One of the main reasons for this discrepancy is that half of Maharashtra's population lives in urban areas, and there is no PHC and family planning service delivery system to cover urban populations, particularly those living in slums.<sup>18</sup> Senior officers of the Directorate also believe that the department's complacency as a result of past performance has led to stagnation. Several attempts made to revamp service delivery systems have not yet yielded results either due to lack of systematic effort or resources. Maharashtra recently introduced a series of disincentives that are both harsh and unrealistic to improve performance in order to reach replacement level fertility within a short span of time.

## Orissa

Orissa selected the newly formed Kurda district to implement the TFA in 1995–96. The government of Orissa introduced a new ECR in 1993–94 and made printed registers available to all sub-centres. Sub-centre workers conducted surveys in all villages in 1994–95 and updated data in 1995–96 to identify ECs. Method-specific targets given to the workers were withdrawn after introduction of the TFA in the district. The directorate toyed with the idea of introducing a birth-based approach to improve

maternal and child health services, but these ideas never took concrete shape. After the introducing TFA in all districts, the Directorate issued instructions to prepare district plans based on norms set by the state.<sup>19</sup> These norms stipulated that the ELA for each sub-centre should not be less than 30 sterilizations, and 30 IUDs, 15 oral pill, and 65 condom acceptors. Districts generally followed these norms in preparing the plans they submitted to the Directorate. Performance was monitored weekly at the sector level. Training of health functionaries in the TFA was completed in all districts by the end of 1997. After introduction of the CNA approach, no further training was conducted. The CNA formats provided by the central government were sent to all districts with instructions that the new formats should replace the old TFA

formats. The Directorate planned to conduct CNA training in 1999. Sterilization and condom performance in the state declined sharply after introduction of the CNA approach while users of oral contraceptives and IUDs increased considerably during

the same period. Orissa faces several unique problems that are major obstacles for effective programme management. In the 1990s, Orissa divided its 13 districts into 30 districts. The infrastructure available in 27 of the new districts is grossly inadequate, and resources are not available to improve the situation. Orissa also experiences severe cyclonic storms almost every year, disrupting the normal functions of all departments. The health department spends most of its energy and resources

In the 1990s, Orissa divided its 13 districts into 30 districts. The infrastructure available in 27 of the new districts is grossly inadequate, and resources are not available to improve the situation.

<sup>18</sup> Tara Kanitkar (ed) Proceedings of the Workshop on Population Policy for Maharashtra: Issues and Challenges, Centre for Health Policy and Research, Pune, 1999 (Mimeo)

<sup>19</sup> K. M. Sathyanarayana and Ranjana Kar, The Target-Free Approach for Family Welfare in Orissa: A Review of Experiences, The POLICY Project, The Futures Group International, New Delhi, 1999



to contain epidemics that follow natural calamities. Still, the state has a relatively good database at the sub-centre level, which could be used to provide services based on client needs. This will only be possible, however, when the state identifies and formulates new strategies to provide quality RH services.

## Rajasthan

Even before introduction of the TFA in 1994–95, the government of Rajasthan decided that the unmet need for family planning services should be the focal point for all programme implementation efforts. To introduce the unmet need concept at the village level, sub-centre registers and report formats were completely redesigned and workers trained in their use. Workers were instructed to conduct surveys

Even before introduction of the TFA in 1994–95, the government of Rajasthan decided that the unmet need for family planning services should be the focal point for all programme implementation efforts.

to identify unmet need for both limiting and spacing methods in the month of May, and districts were to consolidate all information and prepare district plans in the month of June. The extent to which the workers satisfy unmet need has become the basis for performance monitoring and evaluation.<sup>20</sup> In addition, the Department of

Family Welfare introduced concurrent evaluation by external survey research agencies to check for inflated performance reporting at all levels. The new system was introduced in two districts to begin with and rapidly expanded to all districts. By the time the central government decided to implement the TFA, Rajasthan had its new system in operation in the entire state. There was considerable reluctance on

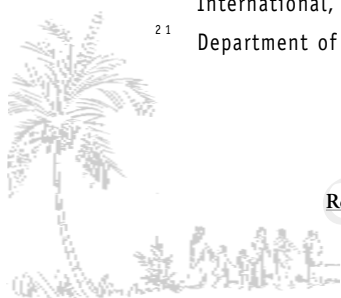
Rajasthan's part to replace its system with the one suggested by GOI. Rajasthan's system, which identifies needs every year in each household, was considered far better than the approach suggested by the central government, which involved a series of calculations to arrive at estimates of client needs. In 1997, the department further expanded its system to identify unmet need for RH services. A monthly feedback system based on reviews of reported performance was established in 1998–99. To review Family planning and RH performance, senior directorate officers visit each district once every two months. Identification of unmet need with the help of household surveys and a revamped monitoring system has helped Rajasthan to improve its family planning performance considerably. It is the only state that has not experienced a decline in family planning performance after introduction of the TFA. The Rajasthan government also formulated a state population policy in 1999 that clearly articulates the goals and strategies for the family welfare programme.<sup>21</sup> Rajasthan, for understandable reasons, has not paid much attention to the CNA approach and the new formats proposed by GOI.

## Uttar Pradesh

Uttar Pradesh selected two districts—Agra, a high-performance district and Sitapur, a low-performance district—to experiment with the TFA. With the help of resources from the USAID-funded Innovations in Family Planning Services (IFPS) Project, the pregnancy-based approach and the unmet need for family planning services approach were introduced in both districts. Registers were designed and workers trained in the use of the new registers. Though family planning performance in both districts

<sup>20</sup> Ram Lubhaya, Target-Free Approach for Family Welfare: A Review of Experiences in Rajasthan, in The POLICY Project (ed) Targets for Family Planning in India: An Analysis of Policy Change, Consequences and Alternative Choices, The Futures Group International, New Delhi, 1998, p 70-101

<sup>21</sup> Department of Family Welfare, Population Policy of Rajasthan, Government of Rajasthan, 1999



declined drastically after introduction of the TFA, a slight improvement in MCH services was observed. In 1996–97, Uttar Pradesh extended the TFA to the entire state, but the training given to workers to implement the new approach was ineffective. Moreover, the state government had deleted the family planning programme from the 20-point programme, and district magistrates were instructed not to monitor family planning programme performance.<sup>22</sup> Overall programme performance drastically declined. After this, the Department of Family Welfare started systematic preparatory work to strengthen the target-free system from 1997–98 onwards. Training was conducted in all PHCs in the state with the help of facilitators and a guide developed specially for that purpose. All workers were trained by November 1997. Uttar Pradesh received the CNA manual to replace the old TFA manual from the central government in March 1998. The Directorate of Family Welfare decided to continue with the TFA formats rather than introduce the CNA formats and retrain all workers. During this period, the department took several decisive steps to improve access to and the quality of a wide range of RH services rather than solely concentrating on family planning. These steps included provision of quality reproductive and child health services through RCH camps, tetanus toxoid (TT) campaigns covering all pregnant women, dai training to increase the proportion of deliveries conducted by trained personnel, and decentralized planning at the district level using a participatory approach. In addition, contraceptive marketing of condoms and oral contraceptives in rural areas is expected to increase spacing method use. The Government of Uttar Pradesh has recently formulated a population policy with clear strategies to integrate services, decentralize

delivery systems, and improve service quality.<sup>23</sup> To realize the policy objectives, the CNA approach has to be further strengthened in the state by conducting annual household surveys to identify unmet need for family planning and RH services. Uttar Pradesh discontinued this practice in the mid-1970s. A common feature in other states, the Department of Family Welfare has decided to reintroduce annual household surveys with the help of simple formats to identify unmet need for RH and family planning services in four districts on a pilot basis. At the same time, the department will develop a more comprehensive management information system (MIS) to cover the entire state in a phased manner.

---

The Government of Uttar Pradesh has recently formulated a population policy with clear strategies to integrate services, decentralize delivery systems, and improve service quality.

---

## Conclusions

Moving from targets to the target-free approach represented a major organizational change, and an enormous challenge to India's public health system. Planning for change involves consensus and clear understanding among stakeholders on the reasons for change, the direction of change, and processes to be followed in introducing change. Due to poor experience with targets, the reasons for the national-level change were clear and in tune with the thinking of the international community on the subject. The groundwork done by GOI to educate and build consensus among stakeholders in support of the TFA, however, was grossly inadequate. Resistance to a change of this magnitude was inevitable and, therefore, strategies to overcome resistance should have been planned well in advance.

<sup>22</sup> J. S. Deepak, *The Community Needs Assessment Approach for Family Welfare: A Review of Experiences in Uttar Pradesh*, The POLICY Project, The Futures Group International, New Delhi, 2000

<sup>23</sup> Government of Uttar Pradesh, *Population Policy of Uttar Pradesh*, 2000.



The GOI, instead, chose a shorter route by announcing the decision and dealing directly with districts without involving state directorates. The delivery of critical instructions, manuals, and formats to districts to reorient workers occurred several months after the introduction of the TFA. Formats prepared to estimate and plan workloads were very complex and involved several calculations based on many assumptions. Those who designed the formats never thought about the capabilities of the primary users of these formats (i.e., health workers at the sub-centre level).

One of the basic problems with the new approach is that it was designed by the central government for use at the sub-centre level. This centrally imposed, decentralized system goes against the core tenet of a decentralized approach for assessing community needs.

Workers in all states found it uniformly difficult to use the new formats. In addition, the training programmes conducted to familiarize workers with the new procedures did not convey the philosophy behind the new system. Workers and supervisors had their own interpretation of the new approach that was different from the original intent of the programme. Not surprisingly, performance dropped substantially in many states. Interestingly, the high-performance states with strong monitoring systems experienced only a marginal decline in performance while the low-performance states with weak monitoring systems could not avert significant declines in performance. TFA, in effect, widened the gap between high- and low-performance states.

One of the basic problems with the new approach is that it was designed by the central government

for use at the sub-centre level. This centrally imposed, decentralized system goes against the core tenet of a decentralized approach for assessing community needs. The formats introduced under the new system again rely heavily on a series of quantitative measures for the sake of quality improvement. The way in which the CNA approach has been implemented undercuts the philosophy behind the new approach.

The CNA approach has achieved some notable positive results, however. Resistance to the change has declined. Those working for the family welfare programme at various levels are now largely convinced about the futility of the numbers game as practiced earlier. There is growing recognition of the need for a thorough review of the programme and for introduction of integrated and decentralized service delivery systems with more emphasis on RH services. The recent formulation of integrated population policies by some state governments is, in a sense, an expression of this need. Several states have also realized that community needs should take precedence over programme needs. Change of this magnitude cannot be accomplished in a short timeframe. Realizing this, many state governments have initiated steps to introduce the change in a systematic and phased manner. The process of change has just begun and will probably take a few more years to achieve the desired results. Instead of believing that the TFA or CNA approach is already in place in the country, GOI should encourage state governments to develop their own approaches for assessing community needs and help them to do this by providing resources and technical assistance until the new systems are fully institutionalized.



Table 1

**Sterilization Performance Based on Service Statistics  
Before and After Introduction of the Target-Free Approach**

State	Before TFA			After TFA	
	1994–95	1995–96	1996–97	1997–98	1998–99
Andhra Pradesh	575,728	520,552	513,127	630,043	730,976
Bihar	206,188	264,927	82,421	196,000	125,000
Gujarat	301,928	289,054	241,945	241,364	250,379
Karnataka	371,535	381,571	384,056	395,624	371,275
Madhya Pradesh	401,855	384,342	371,731	367,092	357,243
Maharashtra	582,454	566,168	518,897	571,476	532,714
Orissa	162,085	148,659	134,825	127,046	NA
Rajasthan	203,118	168,245	200,711	224,140	229,295
Uttar Pradesh	516,970	519,399	266,350	307,799	347,401

Table 2

**IUD Performance Based on Service Statistics  
Before and After Introduction of the Target-Free Approach**

State	Before TFA			After TFA	
	1994–95	1995–96	1996–97	1997–98	1998–99
Andhra Pradesh	338,289	282,933	298,127	293,872	287,190
Bihar	206,551	269,889	156,186	222,744	175,609
Gujarat	473,800	452,180	409,139	401,436	413,189
Karnataka	299,504	345,937	376,247	372,341	337,854
Madhya Pradesh	857,822	797,548	598,012	617,928	576,188
Maharashtra	476,283	470,630	453,321	418,711	402,450
Orissa	193,582	209,074	193,167	245,693	NA
Rajasthan	156,060	168,239	204,765	224,100	232,685
Uttar Pradesh	2,194,522	2,193,488	1,664,021	2,029,847	2,084,468

Table 3

**Oral Pills Performance Based on Service Statistics  
Before and After Introduction of the Target-Free Approach**

State	Before TFA			After TFA	
	1994–95	1995–96	1996–97	1997–98	1998–99
Andhra Pradesh	261,864	242,262	242,987	254,499	224,705
Bihar	65,430	67,214	43,582	56,377	44,940
Gujarat	179,025	172,920	160,123	161,914	172,980
Karnataka	138,232	151,145	157,545	156,494	148,931
Madhya Pradesh	476,277	511,288	494,196	560,167	577,126
Maharashtra	418,194	483,269	375,537	375,187	358,821
Orissa	93,904	99,731	106,472	107,722	NA
Rajasthan	92,268	125,230	484,067	402,489	325,465
Uttar Pradesh	487,250	558,509	514,525	764,044	722,290

Table 4

**Condom Performance Based on Service Statistics  
Before and After Introduction of the Target-Free Approach**

State	Before TFA			After TFA	
	1994–95	1995–96	1996–97	1997–98	1998–99
Andhra Pradesh	1,252,752	820,163	613,013	605,137	539,620
Bihar	194,497	191,305	99,945	78,578	98,875
Gujarat	1,292,225	1,105,558	1,105,687	824,116	889,990
Karnataka	395,108	374,687	358,627	323,021	278,626
Madhya Pradesh	1,987,146	2,004,814	1,761,754	1,650,486	1,545,022
Maharashtra	1,168,747	1,163,775	685,855	594,164	586,489
Orissa	467,838	443,483	369,528	255,967	NA
Rajasthan	475,272	519,048	720,414	470,874	374,345
Uttar Pradesh	2,897,773	2,434,224	1,769,096	2,045,682	1,923,835





Table 5  
Summary of Experience in Implementing the TFA/CNA Approach in India

	Andhra Pradesh	Bihar	Gujarat	Karnataka	Madhya Pradesh	Maharashtra	Orissa	Rajasthan	Uttar Pradesh
TFA in 1995–96	Selected two districts, designed a comprehensive MIS but did not implement the MIS due to lack of positive response from GOI	Selected one district but no instructions were given to the district officers by the Directorate	Selected one district and series of performance review meetings were conducted to arrest possible decline in performance	Selected on high-performing district but no guidance provided on what needs to be done	Selected one district and conducted EC survey	Selected two districts and prepared micro-plans in one district and no plans in the other	Selected one new district with weak infrastructure and conducted EC survey	Selected two districts even before TFA to provide services based on identified unmet need	Pregnancy-based approach and unmet need approach was introduced in two districts in which targets were abolished
Performance in selected districts in 1995–96	Performance declined considerably in both districts	Performance declined considerably	Performance declined only by 17 per cent	Performance of the district more or less remained the same	Performance of the district dropped substantially	Performance in the selected districts declined marginally	Performance declined significantly	Performance improved marginally in both districts	Performance declined considerably in both districts
TFA in 1996–97	Introduced TFA in all districts and also continued with the old system	Introduced target-free training in all districts and the department stopped targets at all levels	Introduced TFA in all districts and conducted household surveys with the help of health workers	Abolished targets but districts took into consideration past performance to arrive at ELAs	Abolished targets and shifted programme implementation to elected bodies of panchayats	TFA was introduced in all districts and GOI formats were modified considerably	Targets were abolished in all districts but state circulated performance norms per sub-centre	State pursued its own system of household surveys to identify unmet need. Serving couples with unmet need was the objective	Abolished targets in all districts and family planning programme was delinked from 20-point programme
Approach									
Current Situation									

Table 5  
Summary of Experience in Implementing the TFA/CNA Approach in India

	Andhra Pradesh	Bihar	Gujarat	Karnataka	Madhya Pradesh	Maharashtra	Orissa	Rajasthan	Uttar Pradesh
Training for TFA system	Training programmes lacked quality and uniform understanding of manuals. Supervision of training nearly absent	Training was done two years after introduction of the new approach	Training for TFA system was not effective and done without systematic planning	Training was conducted after introduction of new system	No training in the first two years	Training was imparted and TFA was renamed as "self - determination of targets approach"	Training was conducted in all districts and manuals and formats were distributed	Training was conducted but more to satisfy GOI than to introduce the new approach	Training was given for TFA system systematically with facilitators and guidelines in place
CNA Approach	Introduced in 1998-99 and workers were given training, manuals and formats	CNA training was not imparted	Completed training all Medical Officers and workers by March 1998	Training conducted and formats distributed	Training conducted and formats distributed and at the same time completely modified ECRs supplied	Four new formats were introduced in addition to GOI formats and training conducted more systematically	No training was given on CNA approach	No training was given and the department followed its own approach and expanded unmet need concept to RH services	No training was imparted on CNA approach
Current Situation	Objectives set in Andhra Pradesh Population Policy are given more importance than numbers generated from below. ELA is based on negotiations with district officers	Neither is the old target system nor new CNA approach based on client needs	Workload identified with CNA formats was much higher than average annual performance of districts. Districts compare past performance and expected workload and arrive at realistic ELAs	Average performance for the past three years and estimates based on GOI norms are compared and ELA is arrive at by each district.	Health workers collect information with the help of ECRs but do not know how to utilize the information. The collected data remains unutilized. Process followed to arrive at ELAs varied from one institution to the other	New formats introduced were not useful to calculate ELA. District tried to use survey data to prepare district plans but could not succeed. Largely follows a combination of old and new approaches	Most of the districts follow the method-specific norms given by the state government. EC surveys are conducted on annual basis to identify eligible couples that need services	Workers conduct annual survey in May to identify unmet need for Family Planning and RH services. Workers are asked to contact couples with unmet need and provide services based on method choice of client	Workers estimate the ELA and consolidated numbers are submitted to Directorate. Then Directorate negotiates with districts to arrive at a number that is realistic and achievable





Table 5  
Summary of Experience in Implementing the TFA/CNA Approach in India

	Andhra Pradesh	Bihar	Gujarat	Karnataka	Madhya Pradesh	Maharashtra	Orissa	Rajasthan	Uttar Pradesh
Monitoring Systems	Performance monitoring systems are strong with high level of political commitment	Monitoring systems were weak before TFA and further deteriorated after TFA	Performance monitoring systems are in place but need to be strengthened	Monitoring systems are in place and no changes introduced after TFA	Monitoring systems are generally weak due to lack of awareness among elected representatives about health systems	Monitoring systems are strong for rural health institutions but urban service delivery systems are weak	Monitoring systems are weak mainly due to formation a large number of new districts. The newly formed districts do not have necessary infrastructure	Monitoring systems were strengthened further at all levels	Monitoring of performance is weak largely due to political interference
Family Planning Performance	Sterilization performance improved considerably while performance of spacing methods fluctuated.	Family planning performance of all methods declined significantly.	Family planning performance declined by 5- 10 per cent for different methods over a period of three years.	Sterilization and IUCD performance marginally increased, oral pill users remained same and condoms users declined.	Sterilization, IUCD and condom performance declined considerably and oral pill performance improved significantly.	Sterilization and IUCD performance marginally declined and oral pill and condom performance declined significantly.	Sterilization and condom performance declined but oral pill and IUCD performance improved significantly.	Sterilization and IUCD performance consistently improved but the oral pill and condom performance fluctuated.	Sterilization performance declined by 40 per cent in 1996-97 and marginally improved after that. IUCD performance remained the same and oral pill performance improved considerably. Condom performance declined.

# Community Needs Assessment Approach for Family Welfare in Andhra Pradesh



Gadde Narayana  
A.Kameswara Rao



The target-free approach (TFA) in Andhra Pradesh was first implemented in 1994-95 in one district and, based on the decision taken by the Government of India (GOI), the new approach was extended to all districts in the state in April 1996. The Department imparted training to all workers, supervisors and medical officers (MOs) on TFA and the methodology to conduct surveys and set their own targets. The experiences of implementing TFA up to March 1997, were earlier reviewed and the report was prepared. This study is, therefore, an update of the earlier effort and records the changes occurred during the year 1997-98 and analyzes the family planning performance.

The main objectives of the study are to : (i) Describe the processes followed to implement the new system; (ii) Record the opinions of personnel at various levels on the new system and its implementation; and (iii) Analyze the impact of the new system on performance. All personnel directly concerned with implementation of the new system at the Directorate of Family Welfare were interviewed. Information was also collected from different personnel representing various levels in the organization in East Godavari and Medak district.

## Target-Free Approach

Preparation to strengthen the target-free system for 1997-98 began in November 1996, with funds provided by the UNICEF. The Directorate of Family Welfare conducted the state level workshop for the district medical and health officers (DMHO), deputy district medical and health officers (DDMHO) and Chief Executive Officers (CEOs) of Zilla Parishads



(district elected bodies) in November 1996. One more workshop was conducted by the Directorate to the statistical officers of the department in March 1997. A series of workshops were conducted in the months of April, May and June 1997, for block level officers such as MOs of primary health centres (PHCs), block development officers, and elected representatives of Mandals. Following this, training programmes were conducted in the months of July and September 1997, to the health workers and the first line supervisors. The female workers were supposed to conduct household surveys and set their own expected levels of achievements. The district level officers felt that it would not be possible for workers to conduct surveys and set their own performance levels almost at the end of the fiscal year. Moreover, the intensive efforts to achieve family planning performance, particularly sterilizations, in a fiscal year are always carried out from September to March. The workers spend most of their time on motivation of sterilization cases and the MOs are not willing to spare their time for surveys and other activities during this period. The Department of Family Welfare had similar experience with implementation of TFA in 1996-97.

The Department of Family Welfare had taken an advance action in February 1997 and asked the Directorate to calculate the expected levels of performance for each district for the year 1997-98. The Directorate-calculated expected levels of performance was communicated to all district collectors by the Secretary of Family Welfare and to all district health and family welfare officers by the Commissioner of Family Welfare.

A letter from the Secretary, Family Welfare addressed to the district collectors stated:

*“The Family Welfare Department has prepared its Annual Plan for 1997-98 month-wise and district-wise. A copy of the plan is enclosed for your information.*

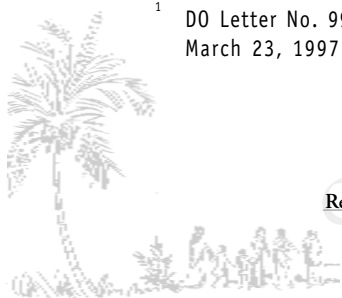
*The first part of the Action Plan related to the regular programme of the Department, i.e., Family Planning and MCH programmes. The ELAs in respect of these two programmes have been shown month-wise and district-wise. Advance planning has been done and is being communicated to you to facilitate achievement of expected levels of performance every month and to avoid rush of activity in the last month of the year. I request you to please review the performance every month and to avoid rush of activity in the last month of the year. I request you to please review the performance every month on family planning and mother and child health programme as per the ELAs communicated in the Plan and ensure that they are achieved within the time frame fixed.*

*The second half of the Action Plan deals with special programmes proposed to be implemented in the State in 1997-98 for the welfare of the family. Seven special campaigns are programmed during the year for family welfare, ORT, ARI, school health check-up and pulse polio immunization. While details of the campaigns will be communicated at the appropriate time, the Action Plan will help you to plan your programme in the district and also help in initiating action for implementation of these campaigns without delay.”<sup>1</sup>*

In a follow-up letter to the district collectors written on April 30, 1997, the Secretary of Family Welfare conveyed the seriousness attached to the achievement of expected levels of performance:

*“Please refer to my letter dated March 22, 1997, enclosing the Action Plan for 1997-98 in respect of Family*

<sup>1</sup> DO Letter No. 9964/D1/97-1 from the Secretary Family Welfare, Government of Andhra Pradesh to all district collectors, March 23, 1997.



Welfare Programmes. In the Action Plan, the ELAs month-wise in both family planning and maternal and child health programmes have been indicated. These ELAs are to be broken up into month-wise ELAs for every village and habitation in the district, based on the number of eligible couples and mother and children who need to be covered under the programmes. I request that this exercise, if not done so far, may please be undertaken immediately and finalized by the end of May at the latest. The reviews of the ANMs, PHC doctors, and DMHOs work should be based upon the month-wise village-wise/habitation wise ELAs. The elected representatives and community leaders in the villages and habitations/gram panchayats/mandals should also be communicated a copy of the month-wise ELAs under the programme and they should be requested to support the efforts of the Health and Family Welfare Department and the district administration in achieving ELAs for each month.

In respect of family planning ELAs, please ensure that a minimum of 60 per cent of the eligible couples covered under permanent methods are those with two children and below. The fertility rate will not decline to the desired level if we keep on covering couples with three children and above under sterilization method. This aspect is to be kept in mind when village-wise/ habitation-wise ELAs are fixed for sterilization.

I request that monthly reviews with PHC doctors and also ANMs may please be conducted at mandal level as far as possible by you, so that the seriousness that the government has attached to the programme is conveyed right down to the grassroot level workers. Elected representatives and community leaders may also be invited to these monthly meetings so that problems, if any, at the field level may be solved in consultation with them and their support generated in achieving month-wise ELAs.

The Hon'ble Chief Minister is reviewing the implementation of the Family Welfare Programme every month against the monthly ELAs fixed and communicated to all districts. I request that every attempt may be made to ensure that the ELAs are achieved as communicated.”<sup>2</sup>

The letter from the Secretary, Family Welfare, triggered a series of similar actions at various levels. The Director of Family Welfare in a letter dated June 11, 1997, addressed to all DMHOs, mentioned:

“The Secretary to Government (FW) has desired to communicate the month-wise ELAs to the district to achieve the cent per cent achievements and also review the programme every month with cooperation of senior officials of the Directorate who will be visiting the districts every month.”<sup>3</sup>

In a separate letter on May 13, 1997, addressing the issues related to family planning performance in urban areas, the Director stated:

“All the district medical and health officers are hereby informed that after careful consideration by the Government, the ELAs in respect of sterilization, IUCDs, oral pills and CC users for the year 1997-98 have been arrived and the same are herewith communicated district-wise for its adoption. The DM & HOs are also informed that the performance in Municipalities is very poor during the year 1996-97 and the Honorable Chief Minister is reviewing the performance of family welfare programme every month. They are, therefore, requested to communicate the ELAs to the Municipal Commissioners and may be requested to take appropriate steps right from the beginning of the year so as to achieve the ELAs given for the year 1997-98. This may be treated most specially urgent and the

<sup>2</sup> DO Letter No., 9964/D1/97-2 from the Secretary of Family Welfare, Government of Andhra Pradesh April 30, 1997.

<sup>3</sup> Letter Ref. No. 4741/DFW/D&E-2/97 from the Director of Family Welfare, Government of Andhra Pradesh, June 11, 1997.



*action taken report may be sent to this office by return post.”<sup>4</sup>*

The DMHO in turn communicated to PHC MOs about the seriousness attached to the programme. For instance, the Medak DMHO in a letter addressed to all PHC and Community Health Centre (CHC) MOs on 16 May, 1997 said :

*“The Secretary, Family Welfare, in her letter cited, has issued certain guidelines for preparation of action plan for the year 1997-98. Accordingly, the distribution of ELAs for the year 1997-98 in respect of all institutions of Medak district is prepared.*

*The Action Plan prepared is based on the expected levels of achievement (ELA) month-wise in both family planning and CSSM programme. These ELAs are to be broken up into month-wise ELAs for every village and habitation-wise in the district, based on the number of eligible couples under programmes. In respect of family welfare ELAs, it should be ensured that 60 per cent of eligible couples to be covered are those with two children and below.”<sup>5</sup>*

A similar letter by the DMHO of East Godavari communicated the message, although less specific in nature, to the PHC MOs in the district:

*“All MOs in the district are informed that the district collector is reviewing the individual MPHAs (male and female) performance every month against the monthly ELAs fixed and insisting that the MOs should ensure the achievement of ELAs as communicated.”<sup>6</sup>*

The Government of Andhra Pradesh, based on the objectives of the State Population Policy, set the ELA for all family planning methods. The expected performance levels were communicated to all the district collectors, the Municipal Commissioners and the DMHOs who, in turn communicated the message to all working below them. Another significant aspect of all this communication is the emphasis given to the review of programme performance and the person going to review it. The letter hinted to review of performance by the Chief Minister at state level and review of performance by district collectors at the district level. Pressure was on the district collectors and the DMHOs to achieve the performance because the Chief Minister intended to review performance and the pressure was on PHC MOs and workers because their performance would be reviewed by the district collectors. Layers of pressure were, thus, built into the system. Another significant aspect of the programme is the early action. Right from the beginning of the fiscal year, the expected levels of performance were communicated to various levels and the monitoring of performance had begun from the first month onwards.

### **Andhra Pradesh Population Policy**

Andhra Pradesh is the first state in the country to formally approve the State Population Policy.<sup>7</sup> The State Legislative Assembly approved the document in March 1998. The Chief Minister formally released the document for the public on July 11, 1998 celebrated as The World Population Day. The document was widely circulated and a series of seminars were conducted at the state level to

<sup>4</sup> Letter Re No 4741/D& E-2/D&E/97 from the Director of Family Welfare, Government of Andhra Pradesh, May 31, 1997

<sup>5</sup> Letter Ref. No. 2182/FW/STAT/97 from the District Medical and Health Officer of Medak District to all Primary Health Centre Medical Officers dated May 16, 1997.

<sup>6</sup> Letter Ref. No. 2665/SO(FW)/96 from the District Health and Medical Officer of East Godavari District to all Primary Health Centre Medical Officers, June 11, 1997.

<sup>7</sup> Government of Andhra Pradesh, Andhra Pradesh Population Policy: A Statement and A Strategy, 1997.



disseminate the contents and to seek cooperation and support of various sections of society. The direction to the programme largely comes from various strategies and implementation mechanisms stated in the policy document.

The Population Policy has set an objective of reaching replacement level of fertility by the year 2001, by promoting usage of spacing methods among newly married and couples with one child, and by encouraging use of permanent methods after two children. Based on this objective, working backwards, number of new acceptors of sterilization and spacing methods every year has been calculated. The state government has taken a series of steps to translate population policy into practice.

Even before the population policy was formally released to the public, the Department has constituted a State Council for Population Stabilization with the Chief Minister as Chairman, Minister of Health and Family Welfare as Vice-chairman, and with several ministers and senior secretaries as members. Later, religious leaders and experts were added to the Council.<sup>8</sup> Similar committees were constituted at district and municipal corporation levels.<sup>9</sup> These committees are not yet fully functional but the constitution of committees in it self is a first step in the initiation of processes to involve people from different walks of life and take their inputs in effective implementation of programme.

The Department of Health and Family Welfare, AP, has taken a few significant steps to improve access to services. Establishment of women health centres is one such measure. In each district four to five PHCs were converted into women health centres to provide round-the-clock reproductive health services. To improve services in remote areas, and also to create employment to a large number to auxiliary nurse midwives (ANMs), a self-employment scheme was launched to train ANMs in reproductive health services. These ANMs will be placed in a village of their choice and they will be allowed to either charge for services or accept payments from the *gram panchayat*.

All the other measures initiated during this period are to improve sterilization performance. Skill training for MOs in double-puncture laparoscopy was launched to cover all government doctors with post-graduate qualification in gynaecology and obstetrics. Similarly, efforts were made to popularize the male sterilization method. Special campaigns were launched in two districts and the number of acceptors of vasectomy, as a result, increased considerably. But in Warangal and Karimnagar districts, traditionally 20 per cent of all acceptors of sterilization operations are vasectomy acceptors. The experiences of these districts cannot be automatically

---

Andhra Pradesh is the first state in the country to formally approve the State Population Policy. The document was widely circulated and a series of seminars were conducted at the state level to disseminate the contents and to seek cooperation and support of various sections of society.

---

<sup>8</sup> GO Ms. No., 137 Family Welfare Programme—Implementation of State Population Policy—Constitution of a State Council for Population Stabilisation—Orders issued on May 6, 1997.

GO Ms., 270 Family Welfare Programme—Implementation of State Population Policy—Constitution of State Council for Population Stabilization—Inclusion of certain names as special invitees—Orders issued on July 9, 1998.

<sup>9</sup> GO Ms. No., 311 Family Welfare Programme—Implementation of State Population Policy—Constitution of District Level Societies for Population Stabilization and Mandal level and Gram Panchayat Level Committee Orders—Issued on August 14, 1997.

GO Rt No 148 Family Welfare Programme—Implementation of State Population Policy—Constitution of Governing Body and Executive Body of Hyderabad City Population Stabilization Society, Orders issued.





transmitted to other districts. The state government, therefore, decided to conduct a study to find out reasons for high acceptance of vasectomy in these two districts before developing strategies and scaling up activities to other districts with low vasectomy acceptance.

New incentive and award packages were introduced to improve performance. The Chief Minister distributed cash awards and merit certificates for best performing districts, best MOs, supervisors and workers, and also a few couples who adopted

sterilization after two daughters, which acts more like a symbolic gesture. Similar packages were also introduced at the district level. A special scheme was also drawn to provide health insurance coverage for couples who adopt a permanent method after one or two children, and this was sent to the GOI for financial assistance. Similarly, the meeting of Health Ministers of southern states, held in Hyderabad, strongly

recommended to the GOI to increase compensation towards loss of wages to sterilization acceptors from Rs. 200 per person to Rs. 500.<sup>10</sup>

In addition to the above measures to improve access to and quality of services at all levels of programme implementation, performance monitoring has become a strong component. The Chief Minister of Andhra Pradesh monitors performance at two levels. He conducts regular monthly meetings with health officers at state level (at times, the district health officers are also invited to the meetings) to review

performance and he also reviews district collectors performance every month, of which family planning is an important component. No previous Chief Minister of the state had given so much importance to family planning. In fact, population stabilization has taken a central role in all development activities. In all public speeches, the Chief Minister mentions the need for reaching population stabilization as early as possible and takes full credit for improved family planning performance in the state.

## Experiences of Implementing TFA at District Level

Information was collected from health functionaries at district, block and sub-centre levels on experiences of implementing TFA in East Godavari, a high performing district and Medak, a low performing district. The processes followed and opinions given are described below.

**East Godavari:** The Commissioner of Family Welfare advised East Godavari district to generate expected levels of performance from grassroot level. A district level workshop was conducted for all MOs for two days from April 22-23, 1997. In turn, the MOs conducted meetings at PHC level for supervisors and workers. The Form 2 manual which was issued as part of TFA, was used to collect information from clients. Based on the information collected, East Godavari set its own targets that were different from the performance levels communicated by the Directorate (see Figure 1).

The differences between the expected levels of performance given by the states and those generated from below was marginal for sterilizations, IUCDs and oral pill users. The major difference was in regard to condom users. The expected

The Chief Minister of Andhra Pradesh monitors performance at two levels.

He conducts regular monthly meetings with health officers at state level to review performance and he also reviews district collectors performance every month, of which family planning is an important component.

<sup>10</sup> Note of Coordination Among Social Sector Programmes, Presented by Government of Andhra Pradesh in Southern State Health Ministers Conference, held in Hyderabad on June 21, 1998.

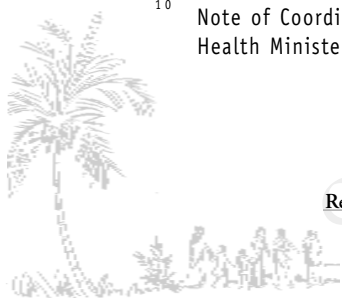
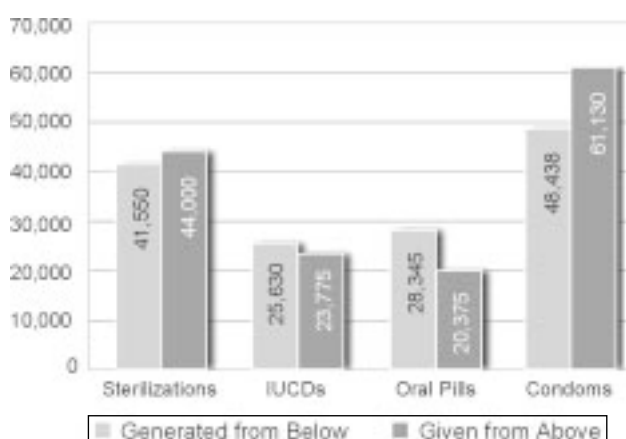


Fig. 1  
**Difference Between Expected Level of Performance Generated From Below and Given From Above in East Godavari District: 1997-98**



performance level given from above calculated much higher condom-users compared to the number generated from below. In any case, performance monitoring is done based on the state-given number and not based on numbers generated from below. East Godavari district, however, demonstrated that it is possible to generate expected level of performance based on client needs.

**Medak :** In contrast to East Godavari, there was no progress in Medak district. Training programmes were conducted at district level for MOs but most of the medical officers could not comprehend the training contents and were, therefore, not in a position to translate the training curriculum into practice. The district had accepted the expected level of performance given by the state and distributed these on pro-rata basis to individual workers.

In both Medak and East Godavari districts, the nomenclature was changed from TFA to participatory planning approach to community needs assessment (CNA), approach causing considerable confusion at all levels in the organization. Each time the nomenclature was

changed, there was a demand for re-orientation training. At the same time, no serious effort was made to conduct the training programmes in a systematic manner. Many trainers did not understand the contents of manuals supplied to them. As a result, the variation between districts in regard to implementation of TFA was significant. The better performing districts could generate data on expected level of performance from below, while the districts with low levels of performance could not. In any case, the performance levels given to districts by the Directorate were taken into consideration for monitoring performance and the expected performance levels generated from below were ignored in 1997-98. The same procedure was followed in the following year.

## **Family Planning Performance in Andhra Pradesh**

### **Sterilizations**

Andhra Pradesh has achieved only 84 per cent of expected level of sterilization performance for the year 1997-98, which is much lower than the percentage achievement in the previous three years. This is not due to low performance in actual terms but due to unexpectedly high levels of performance objective set for 1997-98.

While the expected levels of performance for the years 1994-95 to 1996-97 varied from 600,000 to 525,000, the expected level of performance was increased to 750,000 in 1997-98, which was 43 per cent more than what it was in the previous year. The increase was largely due to the personal intervention of the Chief Minister in one of the review meetings. He opined that the objectives should be high and everyone should make every effort to see that the objectives were achieved. He provided additional funds from state resources to family welfare programme for the first time and promised more, if necessary. Given this, the health



Table 1

**Expected and Actual Level of Sterilization Performance in Andhra Pradesh from 1994-95 to 1997-98**

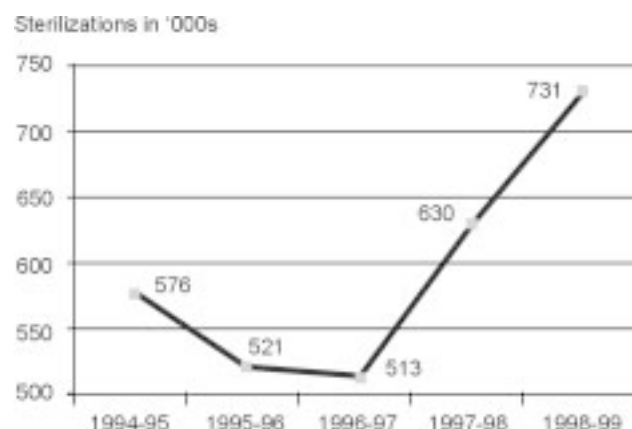
Year	Expected Performance	Actual Performance	Per cent Achieved
1994-95	600,000	575,728	96.0
1995-96	550,000	520,552	94.7
1996-97	525,149	513,127	97.8
1997-98	750,000	630,043	84.0
1998-99	750,000	730,976	97.5

officers had no alternative but to have very ambitious objectives. In absolute terms, the government of Andhra Pradesh has done the highest number of sterilization operations compared to any other previous year in the history of the programme. However, this is a result of enormous pressure exerted on the system at all levels, as is evident from the comparative analysis of quarter-wise performance from 1994-95 to 1997-98. The first quarter sterilization performance was 17.2 per cent of the total performance in 1994-95 and declined to 12.8 per cent in 1997-98. Similarly, the last quarter performance increased from 32 per cent in 1994-95 to 40 per cent in 1997-98.

Increase in performance in the last quarter is due to intensive monitoring, that begins in December depending on the extent of achievement of objectives upto that month. Monitoring of

performance in the last four months of the fiscal year is done on almost daily basis for all institutions. Encouraged by the results of 1997-98 performance, the state retained the expected performance level at 750,000 operations for the year 1998-99. The district collectors were made administrative leaders of the programme. They were given a free hand to mobilize funds locally from industrialists/businessmen, in addition to the flexible resources provided to the district level societies from the state government funds. The Chief Minister, in the innovative Dial CM programme on Doordarshan and Radio, specifically chose population as a subject to appeal to the people to use contraceptive methods. Monitoring at all levels was tightened and more emphasis was placed on districts with traditionally low performance. As a result, the sterilization performance in the state in 1998-99 was the highest ever achieved. Nearly half of the districts exceeded the expected levels of performance and two-thirds of these districts were from the less developed Telangana region.

Fig. 2

**Sterilization Performance in Andhra Pradesh**

Enormous increase in sterilization performance in the state could be gauged by the fact that only 76 operations per 10,000 population were conducted in Andhra Pradesh in 1996-97 and this increased to 95 operations in 1997-98 and reached a peak level of 100 operations in 1998-99.

All sterilization performance reported by the government is not public sector performance but includes private sector contribution. Nearly 30 per

Table 2

**Per cent Quarter-wise Performance of Sterilization Operations in Andhra Pradesh: 1994-95 to 1997-98**

	1994-95	1995-96	1996-97	1997-98
1 <sup>st</sup> Quarter	17.2	16.9	14.5	12.8
2 <sup>nd</sup> Quarter	25.2	23.8	21.2	23.4
3 <sup>rd</sup> Quarter	25.9	23.5	24.0	24.2
4 <sup>th</sup> Quarter	31.7	35.7	40.3	39.6

cent of total sterilization operations in a given year are done by the private sector.<sup>11</sup> In 1998-99, private hospitals might have provided services to 219,292 sterilization acceptors. The private hospitals charge for services provided, depending on the market segment they cater to, varying from Rs. 1,500 to Rs. 6,000 per client.<sup>12</sup> Even if minimum charges are taken into consideration, sterilization acceptors using private sources for services spend about Rs. 328 million on hospital expenses alone. Increasing use of private sector and also growing number of private sector hospitals has considerably contributed to improved sterilization performance.

### Spacing Methods

Andhra Pradesh has the lowest proportion of spacing method-users as per the National Family Health Survey (NFHS) conducted in 1992, and this continued to the same based on preliminary results of NFHS II conducted in 1998-99. There are no serious steps initiated to rectify the situation. The state government has tried to market oral pills and condoms through a network of fair price shops, already in place to sell essential commodities such as rice and cooking oil at subsidized rates. But these shops function only on days the essential commodities are supplied to them. Social marketing of contraceptives through this mechanism is neither feasible nor effective. Although the population policy

document recognizes the need for promotion of spacing methods among newly married and couples with one child, no strategy was developed in year 1997-98, to create demand and also to step-up activities related social and commercial marketing.

### IUCD

The expected level of performance for IUCD was 350,000 insertions but the reported achievement was only 293,872 insertions. Of the total districts, eight districts exceeded the expected performance, 11 districts could not reach the expected levels and the remaining were nearer to expected levels. The performance levels varied from 28 per cent in Medak district to 117 per cent in Prakasham district. The reported performance declined considerably between 1994-95 and 1995-96 and remained more or less at the same level after that. The Department of Family Welfare does not collect information on the extent of expulsions and removals.

Although the population policy document recognizes the need for promotion of spacing methods among newly married and couples with one child, no strategy was developed in year 1997-98, to create demand and also to step-up activities related social and commercial marketing.

### Oral Pills

The expected level of performance was in regard to the number of oral pill-users but the statistics

<sup>11</sup> Jaikishan Desai, Role of Private Sector in Family Planning Services in India, Washington, The Futures Group International 1997 (mimeo).

<sup>12</sup> The client fee information has been collected from different private hospitals in Hyderabad City in 1998, catering to different market segments.



submitted to the Department were in terms of number of cycles distributed. The Directorate divides the number of pill cycles distributed by 13 to get the number of actual users. The information provided is considered highly unreliable. The actual performance for the year 1997-98 was 85 per cent of expected performance but five per cent higher than what it was last year.

### Condoms

The expected level of performance for condoms was not given for 1995-96 but was reintroduced in 1996-97. The performance for the year was 89 per cent of the expected level but declined to 67 per cent in 1997-98. As is the case with oral pill cycles, the number users of condoms are reported to the Directorate but only number pieces are distributed. The Directorate divides number of pieces of condoms distributed by 72 to get the number of users of condoms.

The performance fluctuates based on expected level of performance for the year and the supply situation of contraceptives. No one, even at the Directorate level, give any credence to the spacing method performance reported by districts. Every one

considers the data unreliable and should, therefore, be not taken seriously. Monthly performance reviews at all levels in the organization only concentrate on sterilization performance and not on spacing methods. Andhra Pradesh, even after the abolition of TFA, solely depends on the promotion of sterilization methods to reach replacement level fertility in the next three years. Private sector contribution to spacing method use is also negligible. The wastage involved in free distribution of contraceptives in the state is enormous.

### Fertility Transition in Andhra Pradesh

Andhra Pradesh has been experiencing rapid fertility transition and has almost reached the replacement level of fertility. The total fertility rate (TFR) in Andhra Pradesh in 1991 was 2.59<sup>13</sup> and declined to 2.25 in 1998.<sup>14</sup> The fertility declined among all age groups of currently-married women in the reproductive age of 15-49 years. The main reason for decline in fertility is increased use of modern methods of contraception. Only less than half of the total couples (47 per cent) used any contraceptive method in 1992-93 and nearly 60 per cent of couples used any method in 1998-99. There was no change in percentage of users of spacing methods.

Table 3

#### Expected Performance and Actual Performance of Spacing Methods and Per cent of Expected Performance Achieved

Year	EP	IUD AP	PA	EP	Oral Pills AP	PA	EP	Condoms AP	PA
1994-95	500,000	338,289	67.6	325,000	261,864	80.6	1,520,000	1,252,752	82.4
1995-96	295,160	282,933	95.8	372,331	242,262	65.1	*	820,163	—
1996-97	344,475	298,127	86.4	359,564	242,987	67.6	686,203	613,013	89.3
1997-98	350,000	293,872	83.9	300,000	254,499	84.8	900,000	605,137	67.2
1998-99	350,000	287,190	82.0	300,000	224,705	74.9	900,000	539,620	60.0

EP=Expected Performance; AP=Actual Performance; PA= Per cent Achieved \* Not given

<sup>13</sup> Population Research Centre and International Institute of Population Sciences, National Family Health Survey, 1992 : Andhra Pradesh, Mumbai, May 1995.

<sup>14</sup> Indian Institute of Health and Family Welfare and International Institute of Population Sciences, National Family Health Survey, 1998-99 (NFHS II), Preliminary Report, June 1999.



Only 1.9 per cent couples were current users of modern spacing methods in 1992-93 and also in 1998-99. The main increase in method use was due to sterilization users who increased from 44 per cent in 1992-93 to 57 per cent in 1998-99. Fertility preferences in Andhra Pradesh have undergone major changes in recent times. In 1992-93, only 10 per cent couples with one child and 49 per cent couples with two children opted for sterilization and this increased to 11 per cent for couples with one child and 72 per cent couple with two children in 1998-99. Acceptance of sterilization after two children has become a universally accepted norm in Andhra Pradesh.

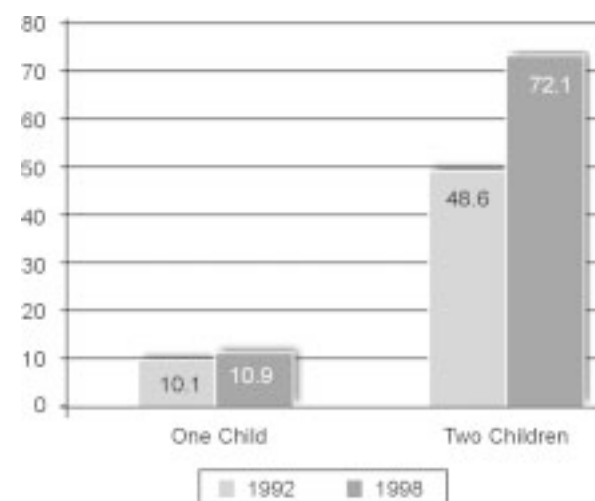
### Maternal Child Health Services

There was substantial improvement in MCH services in Andhra Pradesh in recent times. Pregnant women who received two or more doses of TT, increased from 75 per cent in 1992-93 to 82 per cent in 1998-99 and those who received iron and folic acid (IFA) tablets during the same period increased from 76 per cent to 81 per cent. Institutional deliveries increased from 33 per cent to 50 per cent, and deliveries by trained personnel from 49 per cent to 65 per cent. Percentage of children given all required doses of all types of immunization increased from 45 per cent to 52 per cent and those not getting even any immunization declined from 18 per cent to five per cent.

### Conclusion

The Government of Andhra Pradesh rigorously pursued the family planning programme in 1997-98. Its state population policy was approved and steps were initiated to implement the policy. Although opportunity was given to the districts to generate expected levels of performance, following the methodology prescribed by the GOI, the performance, levels expected from each districts were actually determined at the state level, based on

Fig. 3  
**Percentage of Currently Married Women in Reproductive Age with One or Two Children Who Opted for Sterilization**



Source: NFHS I and II

objectives set to achieve replacement level of fertility in the population policy. The nomenclature of TFA had been changed to participatory planning approach and then to community needs assessment (CNA) approach, causing considerable confusion among workers as well as MOs. Training programmes were conducted at various levels to familiarise workers with new methodology but the quality of training was such that many workers had not understood the basic concepts. Districts with more efficient management systems were able to generate the expected levels of performance from below while districts with weak systems did not attempt the new approach. Training programmes, funded by different agencies, lacked uniformity and the state had issued instructions to conduct the training programmes without putting any effort to improve the quality of training.

In programme implementation, improved sterilization performance became the central theme of the programme. Monitoring by the Chief Minister increased pressure on all functionaries in the organization. More camps were conducted and



performance monitoring in urban areas was—for the first time—given considerable importance. Sterilization performance in 1997-98 was the highest in the history of this programme in the state.

Andhra Pradesh has also succeeded in increasing the number of sterilization acceptors with two or less children. But this has also increased the number needing recanalization services, given the high infant mortality rate (IMR) in the state. However, no significant efforts were made to improve the demand

for and access aspects of spacing methods. Andhra Pradesh continues with its traditional approach of promoting sterilization method to achieve replacement level of fertility by 2001 and is close to achieving this objective. Strong political support to the programme, administrative commitment, mobilization of additional resources, involvement of district collectors in programme implementation and effective monitoring systems are the main factors that have contributed to the success of programme in Andhra Pradesh.



# Community Needs Assessment Approach for Family Welfare in Bihar



Daya Krishan Mangal  
Gadde Narayana



## Background

Bihar has a population of 86 million according to the 1991 Census, which ranks it as the second most populous state in India. Bihar's economy is predominantly agrarian with about 87 per cent of the population living in rural areas and largely dependent on agriculture for their livelihood. About 53 per cent of the rural and 58 per cent of the urban population live below the poverty line. The state recorded a growth rate of 2.4 per cent per annum during 1981-91, which was very close to the national average. The sex ratio in the state has consistently declined over the years: it was 954 females per 1,000 males in 1971, 946 in 1981 and 911 in 1991. The life expectancy for males was 56 years and for females, 54 years.

The age structure of the population is young: the proportion of the population under age 15 years is 41 per cent while that of 65 years and over is four per cent. In 1991, persons belonging to scheduled castes (SC) and scheduled tribes (ST) constituted 15 per cent and eight per cent of the state's population, respectively. The crude birth rate (CBR) was 31 and the crude death rate (CDR) was 9.4 in 1998, according to the Sample Registration System Bulletin.<sup>1</sup>

Although there has been a steady decline in fertility in the state, the total fertility rate was still 4.4 in 1997. The infant mortality rate (IMR) was 68 per 1,000 live births in rural areas and 51 in urban areas. Fertility preferences among currently-married women age 15-49 years

<sup>1</sup> Registrar General of India, Sample Registration System Bulletin, October 1999, Government of India, New Delhi.





showed that 30 per cent wanted no more children and 16 per cent did not want children for at least two years. The unmet need for contraception among currently married women in the reproductive age groups was as high as 25 per cent, of which 11 per cent had an unmet need for limiting methods and 14 per cent had an unmet need for spacing methods. In 1998, only 21 per cent of eligible women in Bihar were current users of any modern method of family planning. Of the total number of modern method users, 89 per cent had accepted sterilization.<sup>2</sup>

The Bihar Department of Family Welfare implemented the target-free approach (TFA) in one district in 1995-96 on an experimental basis and then extended it to all districts in 1996-97, in accordance

with the instructions and guidelines provided by the Government of India (GOI). The TFA was subsequently renamed the community needs assessment (CNA) approach. This study was undertaken in April 1999 to document the process of implementing the approach in Bihar. Information was collected from key personnel in the state Secretariat and Directorate to review the processes followed

and to analyze data on family planning performance over the past four years. District officers in Patna and the medical officers (MOs), supervisors and workers of Danapur block were also interviewed with the help of a checklist specifically prepared for the purpose.

According to senior administrators, the RCH service delivery system in Bihar has many serious problems. The infrastructure at service delivery points is grossly inadequate, many staff positions at various levels are vacant, and the morale and commitment of the workers are low.

## The Target-Free Approach: The Beginning

The state government implements the family welfare programme through a vast network of primary health centres (PHCs), additional primary health centres and sub-centres in rural areas. Prior to the introduction of the TFA, the GOI allotted annual performance targets to the Bihar Department of Family Welfare. The Department, in turn, distributed the targets proportionally to the districts in the state, and the districts set the targets for the PHCs and sub-centres.

According to senior administrators, the reproductive and child health (RCH) service delivery system in Bihar has many serious problems. The infrastructure at service delivery points is grossly inadequate, many staff positions at various levels are vacant, and the morale and commitment of the workers are low. The health staff, more often than not, does not receive salaries and other remuneration on time. The programme budget is released at the end of the fiscal year leaving little time to organize services. Supervision is one of the weakest components of the programme.

Several donor-assisted programmes have been implemented in the state to strengthen health infrastructure and to improve service delivery systems. The India Population Project (IPP) assisted by the World Bank (1990-99) aims to strengthen infrastructure, training, and service delivery. UNICEF funded the Child Survival and Safe Motherhood (CSSM) programme, which covered all districts of the state in phases. UNFPA began providing assistance in November 1997 to the RCH Project in Patna district to improve the quality of services. The World Bank has assisted with the implementation of this project,

<sup>2</sup> International Institute for Population Sciences and Population Research Centre, National Family Health Survey: Bihar, 1992-93, Mumbai.



which will eventually cover all districts in the state in a phased manner. In addition, CARE-India is providing assistance to the Integrated Child Development Services (ICDS) scheme while Action Aid is working with non-governmental organizations (NGOs) to create awareness about Acquired Immuno Deficiency Syndrome (AIDS).

It is within this context that the state decided to experiment with the TFA in Patna, based on the advice given by the GOI in a meeting of State Secretaries organized in April 1995. The Directorate of Health and Family Welfare informed district health and family welfare officers about the decision in May 1995. In the absence of specific guidelines from any quarter, district health administrators were not clear about what was to be done under the new approach. The Chief Medical and Health Officer (CMHO) of Patna called a meeting of all PHC MOs in the district, informed them about the selection of Patna for the TFA for 1995-96, and advised them to concentrate more on improving quality. Only in September 1995 was the CMHO informed about the methodology to be used to help workers set their own expected levels of achievement (ELA). A set of formats used in Tamil Nadu was provided as an example. The formats supplied were complex, and there were no resources to train health personnel in how to use them. It took several months for the PHC MOs to fill them out.

In October 1995, GOI called for a meeting to discuss experiences implementing the TFA. The Director of Medical, Health and Family Welfare and the CMHO of Patna represented Bihar. During the

meeting, GOI instructed the states to prepare district activity plans based on the guidelines provided.

In February 1996, the Department of Family Welfare decided to evaluate TFA in Patna. The Population Research Centre conducted the study. It completed the evaluation in two phases covering four PHCs in each phase.<sup>3</sup> The report on the first phase was submitted to the government on November 18, 1996, and that on the second phase was submitted on February 28, 1997. The reports covered infrastructure in each health institution, quality of family planning services, beneficiaries of MCH services, and characteristics of eligible couples (EC).<sup>4</sup> Yet even before the findings were seriously reviewed, the GOI decided to extend the TFA to all districts in the country as of April 1996.

The TFA manual and report formats were very complex and required information on several indicators.<sup>5</sup> Most of the female health workers, supervisors, and MOs were not able to use the manual or to fill out the formats. Realizing this, GOI called for two meetings in Delhi in August 1997, and consulted some grassroot workers. As a result, the number of formats in the manual was reduced to nine, compared to the 14 prescribed earlier. The revised approach was renamed the CNA approach.<sup>6</sup>

The new manual was not translated into Hindi until June 1998. Printed copies were sent directly to

The TFA manual and report formats were very complex and required information on several indicators.<sup>5</sup> Most of the female health workers, supervisors, and MOs were not able to use the manual or to fill out the formats.

<sup>3</sup> Letter from the State Secretary of Family Welfare addressed to the Director (Evaluation), dated July 2, 1996.

<sup>4</sup> Population Research Centre, "Concurrent Evaluation of Family Welfare Programme in Patna District" November 1997.

<sup>5</sup> Ministry of Health and Family Welfare, Manual on Target-Free Approach in Family Welfare Programme, Government of India, 1996.

<sup>6</sup> Ministry of Health and Family Welfare, Manual on Community Needs Assessment Approach, Government of India, 1998.



districts. Interestingly, no copies were sent to state headquarters. State health officers came to know about the new manual and formats during their supervisory visits to the districts. The Directorate then instructed district officers to follow the new formats when writing their activity plans. The number of formats supplied by GOI to the districts was not, however, enough for all the female health workers. The state government started printing them, but a final decision on their reproduction has not yet been made. Since printed formats were not available, the PHC MOs were advised to consider the ELA for 1998-99 to be the same as those for 1997-98.

### Orientation Workshops

The Department of Health and Family Welfare could not conduct any orientation workshops in the first quarter of 1997 due to a lack of understanding of the new approach. After prolonged discussions, the Department, in consultation with UNICEF, decided to use the training support teams already constituted to impart RCH training. UNICEF had earlier identified 13 professional trainers from the NGO sector who were proficient in participatory training for use in their own projects. These trainers were reoriented in the TFA and were pressed into service to conduct training sessions for trainers by zones. A total of 240 trainers were trained from September to December 1997. Those trainers along with the training support teams trained all workers, supervisors, and MOs by October 1998.

The topics covered in these orientation workshops included the following:

- The historical development of the family planning programme in the country
- The status of the health and family welfare programme in Bihar

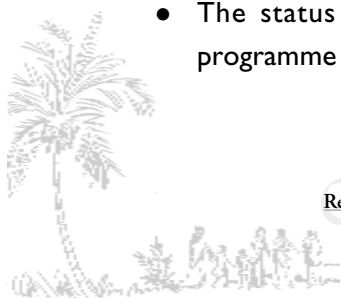
- An analysis of the strengths and weaknesses of the family welfare programme
- Components of the RCH programme
- An assessment of community health and client needs
- Community participation.

Thus, personnel at the sub-centre and PHC levels were oriented in assessment of community health needs for the first time in 1998, two years after the introduction of the approach in the entire state. After April 1996, the Directorate had accepted the ELAs provided by the districts. No targets were set from above during this period. Monitoring of performance was done based on the ELAs.

### Opinions of Health Functionaries on the CNA Approach

Most of the officers at the state and district levels have shared common concerns regarding the TFA and its implementation in the state. They felt that the approach benefited the programme in two ways—the quality of services provided to clients improved; and performance reporting became more reliable particularly for spacing methods. One of the MOs said, “We consider the target-free approach as the tension-free approach as there is no pressure to achieve numerical targets. Workers now concentrate on young and low-parity couples both for sterilization and spacing method services.”

About the manual and formats, the MOs felt the calculations involved in estimating the ELA were very cumbersome. Most of the female workers were not able to follow the procedures suggested. In addition to this, the frequent changes in manuals, formats, and instructions given for the implementation of the new system resulted in considerable confusion—



confusion that often led to inaction. The MOs stressed the need for flexibility in the preparation of sub-centre plans.

## **Reproductive Child Health (RCH) Services**

After the introduction of the TFA, Bihar started shifting the focus of the programme from limiting methods to a more comprehensive package of health services for women and children. Several projects funded by donor agencies are being implementing in the state to institutionalize this shift in focus.

## **The World Bank-Assisted RCH Project**

The RCH Project was implemented in November 1997. All districts were to be covered in a phased manner over a period of five years. The project creates infrastructure, improves service-delivery skills of workers, and involves NGOs in the provision of RCH services. A total amount of Rs. 4,491 million has been sanctioned. To avoid delays, the funds are routed through a newly formed Health and Family Welfare Voluntary Action Society at the state level instead of through the government treasury. Similar societies have been registered at the district level.

The RCH Project provides for several consultants to assist the Directorate in project implementation. The Directorate has initiated recruitment, but the positions have not yet been filled. Currently, the Directorate is collecting and compiling information on the equipment available in different health institutions. Institutions not having standard equipment will be supplied with all required items. Four “mother” NGOs have been identified, though funding to smaller NGOs has yet to begin.

Two types of training programmes are envisaged as part of the project—one for awareness generation

and the other for skill development. The State Institute of Health and Family Welfare (SIHFW) has been recognized as a regional training centre by the National Institute of Health and Family Welfare (NIHFW) for all training programmes. The faculty of SIHFW attended a master trainer’s training programme at NIHFW for three weeks in August–September 1998. SIHFW has so far conducted three training programmes covering three district teams. Each district team was comprised of the MO in charge of district training teams, principals of auxiliary nurse midwife (ANM) training centres, a mass media officer, one gynaecologist, and one paediatrician. These training teams are supposed to conduct training of various groups at district levels. Due to a delayed decision on the mechanism to be used for funding, training at the district level has not yet begun.

## **UNFPA-Funded Reproductive Health Project**

UNFPA initiated this project in Patna in 1995. After a series of consultations and a workshop, UNFPA identified priority areas for RCH services in January 1996. These included prevention of unwanted pregnancies, safe motherhood, reproductive tract infection (RTI)/sexually transmitted infection (STI) management, child survival, infertility problems, adolescent education, and gender equity. Launched in October 1997, for a period of three years, the project uses women’s groups at the district and block levels to highlight health needs of women and to monitor programme implementation.

## **Border Cluster Districts Project**

In 1999, UNICEF selected Bhojpur, Siwan, and Gopalganj districts in Bihar as areas in which to

---

Two types of training programmes are envisaged as part of the RCH project—one for awareness generation and the other for skill development. SIHFW has been recognized as a regional training centre by the NIHFW for all training programmes.

---



reduce by half the infant and maternal mortality rates over the next four years. The specific objectives of the project are to strengthen logistics and enhance the capabilities of service providers to render quality clinical and preventive care to the community. Project interventions include registering all pregnant women, immunizing all children, improving neonatal care, developing new strategies to reduce maternal deaths, and increasing the number of institutional deliveries.

### Contraceptive Marketing

Janani, a registered society, has been implementing a social marketing programme in Bihar since June 1996.

Janani adopted a unique strategy that combines a strong market-based approach with a community-based distribution system for the delivery of the contraceptive services and products to every section of the society with special focus on rural areas.

Janani adopted a unique strategy that combines a strong market-based approach with a community-based distribution system for the delivery of the entire range of contraceptive services and products to every section of the society with special focus on rural areas. In the first phase, marketing infrastructure was established with the introduction of oral contraceptives with the brand

name 'Apsara' and 'Mithun' condoms were added to the programme later on. An extensive field distribution and promotional network of 123 stocking and feeder points was created, feeding 8,000 outlets consisting of pharmacies, cigarette shops, grocery stores, and general merchants. A field force of 40 sales persons and 10 managers ensure that these outlets are served regularly and that the products are readily available to consumers.

The price of the products was decided on the basis of an elasticity test conducted through a well-known market research agency. The low cost of contraceptives to consumers was possible due to

the subsidy offered by the Ministry of Health and Family Welfare (MOHFW) and UNFPA. Janani procures oral pills at one rupees from the government and spends an additional Rs. 1 on repackaging. Similarly condoms are procured at Rs. 0.25 per unit and Rs. 0.25 is spent on repackaging. In 1998, Janani sold 1.5 million cycles of oral contraceptives and 10 million condoms in the state. To further boost the programme, early in 1999, Janani introduced the sale of essential drugs in large trade packs to rural service providers at competitive prices with free 'Mithun' condoms and 'Apsara' oral pills. The cost of contraceptives is built into the sale price of essential drugs. This has helped to involve those service providers who had never shown any previous interest in distributing contraceptives.

Supplying rural shops with low sales volumes is an expensive proposition for any rural marketing agency. To overcome this problem, Janani evolved an innovative approach to involve rural medical practitioners (RMPs) who provide curative services to 75 per cent of all possible clients. Janani trained them and their wives and offered them a package of services. Janani now has a network of 4,300 trained RMPs who are franchisees under the Janani project, which are identified by the butterfly logo. Butterfly Centres are aggressively marketed as centres for good quality family planning services. Each RMP pays an annual membership fee of Rs. 500.

Janani has also created a network of non-specialist doctors under the 'Surya Clinic' franchise to provide clinical family planning services. A training clinic was established for this purpose in Patna in December 1998. The Surya Clinic in Patna provides services at a reasonable cost and conducted 1,784 medical terminations of pregnancy, 866 Copper-T (Cu-T) IUCD insertions, and 82 minilap procedures in one year. After consolidating the programme in Bihar, Janani has plans to expand the programme to other



states. Janani's experiences have clearly shown that couples are willing to adopt family planning methods and pay for services of quality and easy access.

## Family Planning Performance: 1994-95 to 1998-99

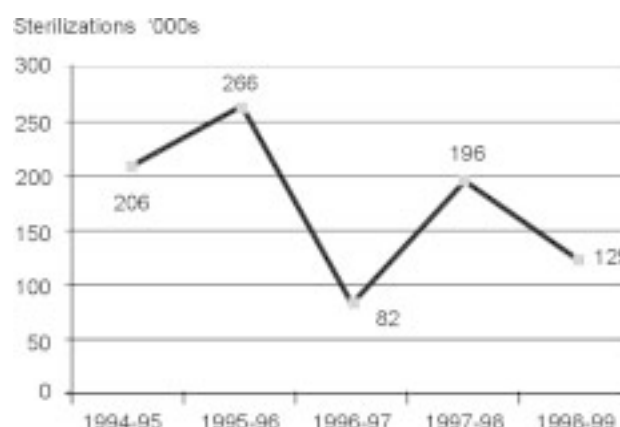
### Sterilization

In 1994-95, before the introduction of the TFA, the state was given a target of 600,000 sterilizations by the GOI. The Health and Family Welfare Department distributed the target to the districts, which in turn distributed targets to PHCs based on the population size of the districts. The actual number of sterilization operations done was 206,188, one-third of the target set. No district except Singhbhum could achieve its target. The extent of target achievement varied from nine per cent to 86 per cent. In almost all districts, 56 per cent of the total target was achieved in the month of March.

For 1995-96, the state was allocated a target of 679,300 sterilizations. Targets were distributed to all districts except Patna, which had been declared as the target-free, experimental district. The achievement for the year was 39 per cent, which was five percentage points higher than the previous year. In 1995-96, 60,000 more operations were done than in 1994-95, but acceptance in Patna declined by 10 per cent with the TFA. Again, except for Singhbhum, no other district achieved the target set.

In 1996-97, targets were abolished in the entire state, and PHCs and districts generated their own ELA. The total ELA for the state was set at 25 per cent less than the target set for 1995-96. Acceptance declined drastically to the lowest level in the history of the programme. Only 82,421 sterilization operations were performed during the first year of the TFA, that was 16 per cent of the ELA or 30 per cent of the previous year's performance. The ELA for the year 1997-98 was set at 10 per cent less

Fig. 1  
**Sterilization Performance in India**



than that of 1996-97. Performance improved considerably but it was still 27 per cent less than it was in 1995-96. In 1998-99, the ELA was set at exactly the same level as it was the previous year, but performance still declined by 37 per cent. In short, after the introduction of TFA, sterilization acceptance in Bihar dropped considerably in the first year and marginally improved in the next two years but never reached the 1995-96 levels.

### Spacing Methods

The analysis of spacing methods was based on service statistics over a period of five years. The first two years represent the target approach period and the next three years, the TFA period. In general, spacing method data are less reliable than sterilization data as they are driven more by the number of condoms, oral contraceptives, and IUDs supplied during a particular year than by the number of actual method users. This methodology remained unchanged even after the introduction of the TFA.

### IUDs

The target for IUDs for 1994-95, a target-approach year, was 508,000 and the achievement was 206,551 (40.7 per cent). Performance varied among districts from 10 per cent to 100 per cent. Almost 35 per



cent of total IUD acceptance was in the month of March, the last month of the reporting year. Of a total of 39 districts, only 12 reported more than 50 per cent achievement, and two districts reported 100 per cent. The state target was increased to 575,200 insertions for 1995-96; all districts were given targets except Patna. Acceptance increased by 30 per cent.

After the introduction of the TFA in the entire state in 1996-97, the ELA was less than the targets given in the previous years. It was lower by 15 per cent for 1996-97, compared to 1995-96, but acceptance declined by 43 per cent during the same period. There was a marginal increase in expected levels in 1997-98 and 1998-99, and there was also a marginal improvement in performance. Nearly 35 per cent of total IUD insertions were done during March, which raises several questions about the reliability of the data. The performance among districts varied from no-acceptors at all to 120 per cent of the ELA.

### Oral Pills

The Department set a target of 159,000 users for 1994-95. Reported achievement was 41 per cent of the target. The differentials in performance among districts were very significant. While Ranchi reported 400 per cent performance, Saharsa reported just six per cent. During this year, half of the total annual acceptance was reported in March. The target in the next year was raised to 180,000 pill-users, but acceptance remained more or less the same. In the

following year, 1996-97, after the introduction of the TFA, the ELA for oral pill users increased by 60 per cent, but acceptance declined by 36 per cent, compared to the previous year. ELA increased further in 1997-98, but performance remained more or less the same.

### Condoms

GOI set a target of 603,000 condom users in 1994-95 in Bihar. Reporting is based on the number of condoms distributed: the number of users is arrived at by dividing the number of condoms distributed by 72. In other words, it is assumed that for every 72 condoms distributed, there is one condom-user. The target achieved in 1994-95 was 32 per cent. No annual target was specified for condom-users in 1995-96. The reported performance was only marginally lower that year than it was in the previous year.

In 1996-97, after the introduction of the TFA, the ELA was estimated to be 562,800 users for the year. Acceptance was only 18 per cent of this number, and further declined to 12 per cent in 1997-98 and to 16 per cent in 1998-99.

### Conclusion

Bihar first implemented TFA in Patna district on an experimental basis in 1995-96. The district officers were not familiar with the approach and, therefore, decided to implement it in one block first and then

Table 1  
IUD, Oral Pills, and Condom Performance in Bihar from 1994-95 to 1998-99

Year	IUD			Oral Pills			Condoms		
	ELA	Actual	Per cent	ELA	Actual	Per cent	ELA	Actual	Per cent
1994-95	508,000	206,551	40.7	159,000	65,430	41.2	603,000	194,497	32.3
1995-96	575,200	269,889	46.9	180,000	67,214	37.3	Nil	191,305	Nil
1996-97	488,600	156,186	32.0	287,800	43,582	15.1	562,800	99,945	17.7
1997-98	492,272	222,744	45.3	322,000	56,377	17.5	635,566	78,578	12.4
1998-99	492,272	175,609	35.7	322,000	44,940	14.0	635,566	98,875	15.6



slowly extend it to other blocks. It took almost seven months to introduce the new formats for data collection and reporting. Even before reviewing implementation experiences in Patna, the GOI decided to do away with the TFA and changed the term to CNA, and thereafter decided to extend the CNA approach to the entire country. The Department of Health and Family Welfare informed all districts about the decision. It took almost one year to conduct the workshops to reorient the workers about the CNA approach. The new formats which were introduced could not be printed due to procedural delays; to date, the workers and supervisors still.

The Department accepted the ELAs for family planning worked out by each district and did not set any targets in 1996-97, 1997-98, and 1998-99. Family planning performance in Bihar significantly declined for all methods after the introduction of this approach. Many attribute the decline in performance to improved quality in reporting, although there was no evidence in favour of that assumption. For all methods, nearly 30 to 40 per cent of annual performance was achieved in the last two months of the reporting period. Programme performance also suffered because of delays in allocating of funds to the programme, non-payment of salaries, large numbers of vacant positions at various levels and poor infrastructure. In fact, there is no evidence to suggest that the CNA approach has resulted in either improved programme management or quality of performance reporting or quality of services.

A majority of workers, even after reorientation training, are still not able to follow the CNA manuals supplied to them. In many districts they have not prepared activity plans based on surveys of community needs. The ELA worked out at PHC and district levels were based on the perceptions of workers and MOs rather than those of clients. The monitoring of performance at monthly review meetings with workers was discontinued. More intensive efforts are required to build capacity and to improve programme management at all levels for the implementation of the CNA approach to be a success.

The GOI initiated an annual district survey to ascertain the status of RCH services in Bihar. The survey<sup>7</sup> covered 21 districts in 1998; the findings are bleak and unflattering. Of the total current users of modern family planning methods, 90 per cent are users of limiting methods. Spacing method use, in general, was insignificant. Nearly two-thirds of all births were third or higher order births. The antenatal services provided to pregnant women in a given year varied from five per cent in the lowest performing district to 26 per cent in the highest performing district. The health and family welfare programme in Bihar needs a major review and revamping in order to improve the health status of women and children.

---

The health and family welfare programme in Bihar needs a major review and revamping in order to improve the health status of women and children.

---





# Community Needs Assessment Approach for Family Welfare in Gujarat



C.V.S. Prasad  
Daya Krishan Mangal



## Objectives of this Study

The Government of Gujarat introduced the TFA at the behest of GOI, first on an experimental basis in one district in 1995-96 and then in all districts in 1996-97.<sup>1</sup> The GOI redesigned the TFA and renamed it the CNA approach in September 1997. Using this approach, health workers are expected to provide quality Reproductive and Child Health (RCH) services and to assist couples in meeting their reproductive health intentions. Family planning targets are not imposed from the top, rather the workers themselves decide on expected levels of achievement (ELAs) based on their assessment of community needs.

This paper describes the experiences in Gujarat with the implementation of the TFA — an innovation of great significance in the state. The main objectives of the study are the following:

- Document the processes of implementation of the TFA and the CNA approach in the state
- Record the experiences of health workers regarding the approach and its implementation
- Analyze the impact of the approach on family planning and the RCH programme.

<sup>1</sup> Letter from the Secretary of Family Welfare, GOI, addressed to all secretaries dated February 9, 1996



Data for the study were collected from interviews with concerned senior programme managers at state and district levels. Field workers in two primary health centres (PHCs) and four sub-centres in the districts of Gandhinagar and Panch Mahal were also interviewed using a checklist, specially prepared for the purpose. Performance data on family planning and RCH services from 1994-1999 were collected and analyzed. Documents and correspondence related to the implementation of the TFA/CNA approach were collected and reviewed.

### **The Target-Free Approach: Experimental Phase (1995-96)**

After the performance review conducted in August 1995, in the meetings, district and state officials explained the TFA and emphasized that it demanded more intensive work and a higher level of commitment to serving the community.

In 1995, the Ministry of Health and Family Welfare (MOHFW) of GOI decided to implement a TFA to family planning on an experimental basis in one or two districts of each state in the country. Initially, Gujarat identified Valsad and Panch Mahal, based on their consistently high family planning acceptance rates. Later it was decided to implement the TFA

in Valsad only. The Commissioner for Health and Family Welfare informed Valsad district officers about the TFA in March 1995 and that no specific targets for family planning services were to be allotted for the year 1995-96. The MOHFW, GOI, suggested indicators for monitoring programme performance in the experimental districts. These indicators were couple protection rate (CPR), the age and parity of acceptors, antenatal care (ANC) registration and immunization of children less than one year of age.

The Additional Director for Family Welfare briefed the district health officials of Valsad on the TFA at Gandhinagar in April 1995. Later, all PHC medical officers (MOs) in the district were instructed in TFA

in small groups. Trainers explained that the approach represented a paradigm shift and that now the MOs should place more emphasis on involving the community in assessing its need for RCH services, including family planning. They should further plan services based on perceived needs and should ensure the services provided would be of high quality.

The same message was, perhaps, not properly or adequately communicated to the field workers; hence, they were confused about the concept. As a result, performance suffered. In fact, the performance review conducted in August 1995 alarmed district officials to the point that state and district programme managers convened a meeting of all PHC-MOs to discuss the situation and to suggest corrective measures. This was followed by a series of meetings at the PHC level for the staff of the health and the Integrated Child Development Services (ICDS) departments.

In the meetings, district and state officials explained the TFA and emphasized that it demanded more intensive work and a higher level of commitment to serving the community. Health workers were instructed in how to estimate ELAs for sub-centre areas. District programme managers reiterated that all couples with perceived needs for family planning and maternal and child health (MCH) care would have to be provided high-quality services. Illustrations were used to emphasize that before the introduction of the TFA, each sub-centre worker was serving 215 family planning clients, while under the new approach each worker would have to provide family planning and MCH services to 390 clients. In these training meetings, the programme officers emphasized that under TFA there was no room for complacency and reiterated that more intensive efforts would be needed to provide improved and better services to all clients with perceived needs. Programme managers emphasized



regular updating of eligible couple registers (ECRs) for assessing clients' needs and for providing family planning and MCH services.

Acceptance of family planning declined in Valsad during 1995-96, though a better profile of acceptors in terms of age and parity was reported. Valsad reported 14,590 sterilization acceptors in 1995-96, a decline of 17.2 per cent over the number in 1994-95 (16,989). Likewise, acceptance of Intrauterine Devices (IUDs) declined by 21 per cent, pills by 12 per cent, and condoms by 16.5 per cent, compared to 1994-95. However, state and district officers were content with the new approach. According to them, a marginal decline in the first year of implementation of an innovation of this nature was acceptable as long as it was accompanied by improvement in the quality of services.

The MOHFW/GOI organized a meeting in March 1996, to review the experimental phase of TFA implementation. The district and state officers representing Gujarat gave positive feedback.<sup>2</sup> They said that the slight decline noted in performance was not a concern at this stage, rather that it was to be expected. However, they expressed a need for more intensive efforts to train field workers to help them understand the philosophy of the new approach, enhance their skills in assessing perceived community needs, and develop decentralized plans for effectively serving the community. They also suggested that the expansion of the TFA to the remaining districts of the state should be done in a phased manner.

### **Expanding the TFA**

The MOHFW announced that it planned to expand the TFA to all districts in the country in a meeting of State Secretaries on February 1-2, 1996. In short, beginning in April 1996, all method-specific targets

would be removed from the family planning programme. The letter from the Secretary of Family Welfare, GOI, dated February 9, 1996, addressed to all State Secretaries of Family Welfare included the following information:

*"Please refer to the discussions in the meeting of State Secretaries on February 1-2, 1996, on the issue of extending TFA all over the country in 1996-97. This could be converted to an excellent opportunity to make family welfare in India a truly people's programme. As discussed in the conference, grassroots workers may get together to give an estimate of likely acceptance of different family welfare activities in 1996-97 for every quarter in their jurisdiction to form part of their PHC-level family welfare and health care plan..."*

The letter contained broad guidelines/suggestions for implementing the TFA. The state promptly called for the removal of targets and the implementation of the TFA in all districts and municipal corporations in a meeting in May 1996. State officials requested district health officers of parent districts to implement the approach in newly established districts also. The district officers in turn told the staff of community health centres (CHCs)/PHCs about the removal of family planning targets and shared a copy of the letter from the State Directorate with them.

The Secretary of Family Welfare, GOI, also informed all district collectors about the implementation of the TFA in a separate communication dated March 4, 1996, and asked them to organize orientation workshops at the district and PHC levels during the month of March and April in 1996. However, these workshops could not be organized due to difficulties in funding and a lack of guidelines, instructions and resource persons.

<sup>2</sup> Letter from Secretary Family Welfare, GOI, addressed to all district collectors dated March 4, 1996



Nothing much happened during the next five to six months because there were no clear guidelines or instructions on implementing the TFA and developing PHC and district plans. Other states in the country had similar experiences. Realizing this, the MOHFW organized a two-day workshop for state officers in New Delhi in September 1996 in which the TFA and its implementation were discussed. A follow-up plan for organizing state and district orientation workshops was developed and finalized.

In November 1996, an orientation workshop was held in the state for concerned officers of the Health and Family Welfare Directorate, for regional deputy directors, for district health officers, for additional district health officers, for chief development officers, for immunization officers, and for commissioners of municipal corporations, alongwith medical college professors of preventive and social medicine (PSM), paediatrics, and gynaecology. In the workshop, the TFA was explained; and the process of preparing sub-centre, PHC, and district plans was discussed, as were the planning formats in the manual. A plan was finalized for conducting district-level orientation workshops. The participants in the state-level workshops were assigned the responsibility of organizing and facilitating the district workshops.<sup>3</sup>

The district workshops for medical officers were conducted during April and May 1997, while block-level workshops for the staff of health and ICDS departments were held during June and July 1997. In all, 2,422 medical officers and 16,890 field staff were trained in the TFA in these workshops. Workshops for urban areas were held in the latter part of 1997. They lasted two days and focused on the preparation of district family welfare and health

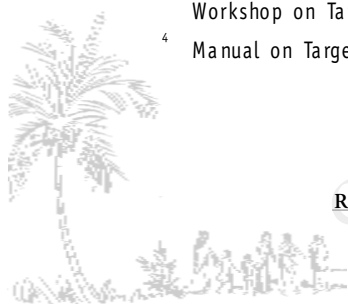
care plans using Format 3 from the TFA manual. Block-level workshops focused on estimating community needs and developing sub-centre plans using Format 2 from the manual.

The MOHFW supplied the manual in English to the state in May 1996. It was translated into the local language and was used in district and block orientation workshops as background material.<sup>4</sup> The expected levels of achievement for family planning and RCH services were estimated, using the methodology described in the manual. The manual included norms for estimating the workload for family planning and other MCH services by method. The norms specified the proportion of couples to be covered with spacing and limiting methods based on parity and age of wife. According to the norms, 50 per cent of married women with no children should be provided spacing methods; the same proportion of women with one child should be motivated for IUD and pill acceptance. Half the women with two children should be motivated for IUD acceptance while the remaining half should accept sterilization. One hundred per cent of women with three or more children should be motivated for a limiting method.

The workloads estimated using these norms were unrealistically high. The programme managers, therefore, decided to adopt the targets of the previous year (1995-96) as expected levels of performance for the year 1996-97. Thus, even with intensive efforts to orient staff at all levels, confusion prevailed over the validity of the approach and the suggested norms for estimating ELAs, particularly for family planning. Improvement in the quality of family planning services was equated by and large with increased acceptance by younger couples with lower

<sup>3</sup> N. D. Ghasura, Bella C. Patel and M. E. Khan, "Implementing the Target-Free Approach in Gujarat," Presented in the National Workshop on Target-Free Approach, Lucknow, November 24-25, 1997

<sup>4</sup> Manual on Target-Free Approach, Ministry of Health and Family Welfare, Government of India, 1996



parity. Therefore, emphasis was placed on recruiting such couples as family planning acceptors.

Despite the repeated message in orientation workshops and monthly meetings that under this approach the responsibility of the workers would increase, grassroots workers interpreted the TFA differently. Some construed it as no work or no serious commitment while others took it as a tension-free approach and relaxed. It is noteworthy that most TFA workshops were conducted in the latter part of 1997, while during the financial year 1996-97, only state-level orientation workshops were held. Thus, during 1996-97, the implementation of the TFA and preparation of sub-centre plans were done amidst a state of confusion due to a lack of clear instructions, guidelines and proper training of field workers.

Meanwhile, MOHFW received several reports that the manual had too many complicated formats that were difficult for field workers to comprehend. The Ministry, therefore, organized a series of workshops on August 19 and August 28, 1997, to simplify the manual and reduce the number of formats. Based on the recommendations of the workshops, the manual was revised, and in a meeting in New Delhi in September 1997, State Secretaries approved the revisions. The approach was then renamed the Community Needs Assessment or CNA approach, in order to remove the misunderstanding and confusion resulting from the misinterpretation by the field workers of the TFA as the no-work approach. The number of formats was reduced from 14 planning and reporting formats for the TFA to nine formats for the CNA approach.

The MOHFW dispatched the CNA manual in English to all states in 1998. Meanwhile, states continued to follow the earlier manual.

## The Community Needs Assessment Approach

The CNA approach further emphasized decentralization in the planning process and reinforced the need for community consultations at the village level to develop sub-centre plans for providing quality services, including family planning, under the RCH programme. More emphasis was placed on issues related to improving quality of services at all levels in the PHC system. In this context, it was reiterated that decentralized plans for all levels—from sub-centres to districts—were to be developed after assessing the health needs of couples by talking directly to them, and by involving formal and informal village leaders and women's groups in the process.

The CNA manual describes the revised methodology for preparation of sub-centre, PHC, and district plans in detail. It suggests that a household survey should be conducted by the auxiliary nurse midwives (ANMs) during February and March, using the formats in the manual. Community needs for RCH and family planning services estimated using the household survey findings should be validated in discussions with Anganwadi workers (AWWs), members of *Mahila Swasthya Sangh* (MSS) and Panchayat health committees. The estimates of ELAs or community health needs for the current year should be compared with the achievements of previous years. The estimates should be 5-25 per cent higher than the actual performance of the previous year; if calculations do not yield those results then the estimates should be carefully reviewed. The manual further suggests that "Attention should be paid to family planning services, particularly male sterilization since it is only three per cent of the total

---

The CNA approach further emphasized decentralization in the planning process and reinforced the need for community consultations at the village level to develop sub-centre plans for providing quality services, including family planning, under the RCH programme.

---



number of sterilization operations,” and that estimates should also be compared with the estimates from demographic calculations. The manual concludes, “It is important to understand that neither the requirement assessed on the basis of household survey nor the figures arrived at by the demographic calculations should be treated as final or beyond question; actually, it would be highly desirable to study past trends. Talk to local functionaries of different departments such as Anganwadi workers, practitioners of Indian Systems of Medicine, and Mahila Swasthya Sangh.”

According to the CNA manual, the PHC plan would be a compilation of all sub-centre action plans under

According to the CNA manual, the ANMs would play a key role for which they would undergo frequent in-service training to upgrade their knowledge and skills and understanding of their duties.

that particular PHC. The MO in charge of the PHC should calculate the requirements for drugs, vaccines, equipment and other supplies to provide the services included in the plan. The MOs could easily estimate requirements based on existing stocks of supplies and the net requirements for serving the

perceived needs of the population. Only information not generated at sub-centres would be added at the PHC level, e.g., the number of medically terminated pregnancies (MTPs) and the number of cases of reproductive tract infections (RTIs) and sexually transmitted infections (STIs) treated and referred. All additional information required is printed in capitals in Form 2 of the CNA manual. It also describes detailed procedures for preparing first referral unit (FRU) and district family welfare and health care activity plans.

The manual clearly enunciates what grassroots workers should do to provide RCH services using

the CNA approach. According to the manual, the ANMs would play a key role for which they would undergo frequent in-service training to upgrade their knowledge and skills and understanding of their duties.

## Training in the TFA/CNA Approach

TFA training was conducted in 1997 with the help of UNICEF, the State Institute for Health and Family Welfare (SIHFW) and facilitators from medical colleges, but no training or orientation sessions have been conducted in CNA since it was introduced in 1998 nor are any proposed. However, programme managers have informed medical officers in health centres and district hospitals about the new approach during routine monthly meetings.<sup>5</sup>

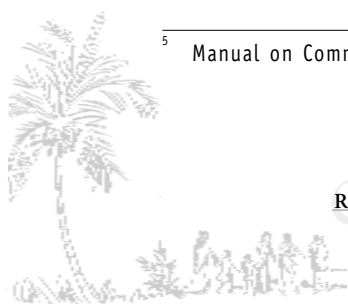
During our field visits, we observed that the Director of Education and Information, the State Demographer, and other concerned state officials were training computer/statistical assistants and other clerical staff at the District Health Office in RCH and the CNA approach. The objective was to involve them in programme monitoring at the grassroots level and to assist them in preparing sub-centre plans.

The CNA manual in English has been supplied to all states including Gujarat. During our field visits, we saw the manual (in English) in the hands of the district health officers in both Gandhinagar and Panch Mahal; however, they had only one copy each. They had not copied it or distributed it to the PHCs. Grassroot workers are meanwhile forced to use planning and reporting formats in English, a language with which they are not very comfortable.

## RCH Training

Six-day, UNICEF-supported RCH training programmes for ANMs were conducted from

<sup>5</sup> Manual on Community Needs Assessment Approach, Health and Family Welfare Department, Government of India, Delhi, 1998



January to April 1998, by UNICEF district training teams and three to four teams of trainers at the district level. The curriculum was designed by MOHFW/UNICEF for ANMs and their supervisors. One session was exclusively devoted to the new approach. One of the SIHFW trainers said, "After the RCH training, all the ANMs were able to develop sub-centre plans using the methodology suggested in the TFA manual. However, some ANMs required assistance from medical officers of PHCs."

Later, MOHFW modified the approach and the CNA manual was sent to the state in 1998. The manual and formats have been translated into the local language by the state. The staff at the SIHFW feels, however, that the translation needs to be simplified further so that the workers will be able to understand it. The printing of the manual and the formats will be done once the translation is finalized. No separate training or orientation was done in the revised approach or in the use of the simplified planning and reporting formats. The SIHFW trainer reported that training or orientation in CNA would be carried out as a part of the training programme for ANMs proposed under the RCH project.

### **Experiences of Functionaries with the TFA/CNA Approach**

As mentioned previously, the TFA/CNA approach envisaged that functionaries at all levels of the service delivery system would work rigorously to develop family welfare and health care activity plans annually and would involve the community in the process. The plans were to be prepared every March before the start of the new financial year. After assessing community needs, the workload for each RCH and family planning service would be estimated in realistic terms at the sub-centres. In addition, the availability of supplies including contraceptives, equipment, and manpower would be stipulated. This activity plan was to enable health

workers to plan their day-to-day work routines and make overall plans for the year.

In all four sub-centres visited in the districts of Gandhinagar and Panch Mahal, the staff prepared the plans for 1998-99 with the help of their respective supervisors. To be more specific, the supervisors assumed primary responsibility for computing the workloads. There were instances in which the supervisors had correct information about the population of the villages in the sub-centre, including the number of eligible couples (EC), the number sterilized, the number currently using a modern spacing method, the number potentially needing counselling services, and the distribution of couples by number of living children. However, the ANMs contacted were not confident about the process of assessing community needs for family planning and RCH services, nor could they produce proper records. Also, a discrepancy was observed between the lists of EC by parity and lists of couples with unmet need for family planning maintained by the ANMs and supervisory staff at the PHC. Though it is not proper to generalize on the basis of these four observations, one may agree that the approach is not yet well understood at the sub-centre level by the ANMs while supervisors, on the other hand, have a very good understanding. This difference might be mainly attributable to the differences in their education and exposure levels.

A group discussion with six MOs from different PHCs and CHCs in the Panch Mahal district indicated that they were well versed in the TFA. They confirmed that training programmes had been conducted at all levels during 1997. They admitted, however, that they did not know about the recent changes to the CNA approach. In spite of this, their action plans were prepared and submitted on time to the district office, and the district plan was prepared following the guidelines in the TFA/CNA



manual. At the state level, the Health and Family Welfare Directorate compiled the state plan from 1996-97 to 1998-99 and submitted it to the MOHFW.

During discussions, one state officer commented on the process of preparing district activity plans. He said, “Decentralized district plans are prepared at each district following the CNA approach. The ANMs prepare sub-centre plans based on the household survey carried out during March and the consultations with the community. The sub-centre plans are collated at the PHC to form the PHC plan.

All the PHC plans are collated and plans of urban areas are added to them to prepare district plans on Form 4 of the CNA manual. The district sends a copy of it to the MOHFW directly and one copy to the Department of Family Welfare in the state. The state prepares its plan by collating the district action plans and finalizes the estimated workload for each district.”

State officers felt that the CNA approach has resulted in improvement in the quality of data reported by the field workers. There was a slight decline in performance initially, but it has stabilized now.

He further said, “The plan prepared by the district is reviewed to see the workload estimated by the district. If it is found to be too low then a revised workload is estimated based on the past performance during the last two-three years, the number of unprotected EC in the district, and the capability of the district. The revised workload is then communicated to the district and to GOI. Such revisions were done in case of two-three districts only during the year 1998-99. The programme performance was monitored based on the workload submitted by the districts. No targets are given by the state in any form. The performance is also monitored on qualitative aspects such as age of wife and distribution of acceptors according to number

of living children. The district performance is discussed with the Chief District Health Officer during the meeting held every three months at the state level.”

During discussions it emerged that all the workers are not able to prepare sub-centre plans as envisaged by the TFA/CNA approach, so they do need more training on a regular basis. Some information is provided at the PHC monthly meetings, but it is not enough. One state officer said, “The statistical and computer assistants are trained for two days every year. They in turn provide training to other staff at the PHC level. The formats are still in English and many workers are finding it difficult to comprehend them.”

State officers felt that the CNA approach has resulted in improvement in the quality of data reported by the field workers. There was a slight decline in performance initially, but it has stabilized now. The performance in MCH indicators is better than that in family planning. The workload for MCH indicators was prepared only last year, and during this period performance had not declined.

The manual provides formats for reporting and monitoring performance every month at different levels against the estimated level of achievement: sub-centre, PHC, CHC, FRU, district, and state. Compared to the formats in the TFA, those in the CNA manual are fewer and simpler. The formats cover information on the previous month’s performance, the current month’s performance, and cumulative performance up to the month for the previous year, and cumulative performance for the current year vis-à-vis the expected achievement in the current year.

During our field visit, we observed at both district health offices that the staff was not very comfortable





filling out the reporting and monitoring formats, perhaps because they did not thoroughly understand all the columns. The district health officers did, however, understand them and were helping their clerical/computer staff in the preparation of the progress reports. Unfortunately, the health officers could not spare enough time for this purpose and, therefore, use of the formats was not progressing well. We were told that most of the districts are reporting performance on the formats suggested in the CNA manual as well as on the TFA formats, while only 50 per cent of districts are sending performance reports on Format 9 of the CNA manual.

The MOHFW suggested computerizing the reporting formats and involving the National Informatics Centre (NIC) network in the process. The NIC was entrusted with the responsibility and started computerizing the formats, but due to pre-occupation with other activities at the district level, adequate time was not given to compilation and onward transmission of reports through the NIC network. The state government has frequently written to the NIC asking them to complete the process.

Besides implementing the CNA approach, the state government is implementing other projects and interventions to increase access to and quality of RCH and family planning services. A few important projects and activities are briefly described below.

### **Innovative Projects and Activities**

#### **World Bank-Assisted RCH Project**

The state government submitted the RCH project to the MOHFW on March 16, 1998, for funding worth Rs. 152 crore (a crore is 100,000,000). It is a five-year project to improve the quality of RCH services that will be implemented in all districts in a phased manner. The first phase is for two years; expansion will be based on the experience gained

therein. In March 1998, the MOHFW released the sum of Rs. 3.09 crore as an ad hoc grant for minor civil works, contractual staff, procurement of drugs and procurement of other supplies. Over and above the RCH project, GOI has released the sum of Rs. 2.25 crore for the RCH sub-project in Vadodra District against the total project cost of Rs. 10.71 crore. The funds released by GOI on March 31, 1998, could not be used as they needed revalidation, which was not received until August 31, 1998.

The Vadodra project is also for five years. Interventions include information, education and communication (IEC) orientation activities, development and procurement of IEC materials, monitoring and evaluation, strengthening of infrastructure, and strengthening of RCH services at FRUs/CHCs with provision of RTI/STI services. Of the total Rs. 3.95 crore sanctioned until September 1999, Rs. 2.20 crore has been spent. Major expenditures were for construction of 50 sub-centre buildings with maternity wards and labour rooms. Other activities were minor civil works at PHCs, orientation training activities for newly married couples, folk IEC programmes, counselling camps for adolescents, orientation camps for elected female representatives and other women in 200 villages, 12 block-level workshops for traditional birth attendants (TBAs), and a baseline survey.

Besides implementing the CNA approach, the state government is implementing other projects and interventions to increase access to and quality of RCH and family planning services.

The RCH project provides for additional positions at the state level for effective managers, but the positions have not yet been created. However, existing positions have been re-designated to satisfy MOHFW requirements for providing funds under the project. The project also provides positions for five consultants. These positions have been



advertised and a selection committee has been formed by the state. To date, selections have not been made.

Gujarat receives funds for the RCH project from GOI through the normal treasury channel. However, to facilitate the flow of funds and provide requisite flexibility in implementation of the project, the state has created RCH societies at the district level under the chairmanship of the District Chief Executive Officer. Project funds are placed at the disposal of the society.

The SIHFW has been identified as a nodal agency for all RCH training activities in the state. Training committees have accordingly been constituted at the state and district levels and awareness-generation training programmes (AGTP) have been organized in coordination with UNICEF for state, district, sub-district and *taluka* personnel and for grassroot workers in health and related departments. Personnel are trained in groups of 20-30 in divisional training centres by district training teams and by the faculty of ANM training centres/Lady Health Visitor (LHV) training schools. These two-day training sessions cover the topics recommended by NIHFW including the concept of RCH, strategies for programme implementation, the population explosion, maternal care, adolescent health, RTIs/STIs, and methods of family planning. Socio-demographic data by district was also presented. The sessions were interactive, and audio-visuals were used to make them interesting and effective. The AGTPs started in December 1998 and, to date, 218 groups have been trained, covering 4,300 functionaries in the state. The total number of trainees is approximately 90,000.<sup>2</sup>

Besides the AGTPs, skill-based training for all categories of health functionaries is another important intervention of the RCH project, though

it has not yet started in the state. The state does conduct the following skill-based training programmes:

### **Medically Terminated Pregnancy (MTP) Training**

There are eight MTP training centres in the state; six centres are located at medical colleges and two at other places. One MO is sent for training to each training centre for 15 days as per GOI circular dated August 4, 1998. For certification, a trainee has to assist 10 MTP cases, perform 10 MTPs under supervision, and perform five MTPs independently. The trainees are trained in the suction technique of conducting MTPs of less than 12-weeks duration. After the successful completion of training, a certificate of Panel Surgeon is awarded. Fifty-four MOs have been trained since 1996-97. The trainees are selected from PHCs where operating theatres are available and instruments for MTP have been supplied.

### **Laparoscopic Sterilization Training**

Only a qualified gynaecologist with at least one year of experience can receive training/orientation at one of the five medical colleges in the state. Training lasts one month, of which 15 days are in the institution and 15 days are in camps. Trainees are required to assist with 25 sterilization cases and perform 25 sterilizations in the camps. The trainees are examined by the institution for proficiency and, if found successful, are awarded a certificate of Panel Surgeon. Fifty doctors were trained in laparoscopic sterilization between 1996 and 1999.

### **UNFPA IPD Project**

Kutch, Sabarkantha, Banaskantha, Surendra Nagar and Dahod districts are covered under the UNFPA Integrated Population and Development (IPD) project, which was sanctioned on June 4, 1999. The project focuses on decentralization, quality



of care, introduction of a more comprehensive package of RCH services, and on providing women access to information and a role in programme management. The districts in the project were chosen based on socioeconomic criteria and health needs. Three-fourths of project activities are directly related to RCH; the remaining one-fourth is concerned with social development. The project is under the direction of a state committee headed by the Chief Secretary and a state project management committee with representatives from the project districts. To facilitate implementation of the project and ensure the smooth flow of funds, the district RCH societies created under the World Bank RCH project have been restructured. Each project district has an RCH committee that includes a UNFPA representative. Project funds have been released by GOI to the state, though the state has yet to release the funds to the district societies.

### **UNICEF Border Cluster Districts Project**

GOI has asked UNICEF to work closely with state governments to accelerate the implementation of an RCH programme in selected border districts. UNICEF is, therefore, funding a four-year project in cluster districts with the objective of reducing infant and maternal mortality rates (MMR) by 50 per cent. In Gujarat, Danga and Valsad districts were selected in consultation with the state government. The specific objectives of the project are to strengthen logistics and enhance capabilities of the service providers to offer quality clinical and preventive care to the community. Specifically, the project aims to do the following:

- Register 100 per cent of pregnant women
- Immunize 100 per cent of children

- Reduce childhood mortality from common diseases
- Reduce neonatal deaths by improving neonatal care
- Identify causes of maternal mortality and devise strategies to reduce it
- Promote birth spacing and the use of limiting methods of contraception
- Improve the quality of deliveries in public and private institutions
- Improve the functioning of FRUs
- Provide RTI/STI and AIDS-related services.

Key components of the project are community, need-based, sub-centre service delivery; community-based monitoring and management of sub-centres; an effective logistics system; an improved referral system; and training of health workers.

### **Mahila Sammelan (Women's Conference)**

The theme of WHO Day in 1998 was "Safe Motherhood;" it was celebrated with much fanfare and a massive mobilization of the community and of women's organizations in particular. The focus of the weeklong celebration was the health exhibition and the *Mahila Sammelans*, which were addressed by the Chief Minister, the Minister of Health, and other ministers and senior officers of the state. Over one lakh people visited the health exhibition. In addition, a *Jeevan Raksha Yatra* was organized to cover 10 per cent of Gujarat's villages. In this activity, a team of medical, paramedical personnel and nursing students camped in the



villages and provided information and services to the residents.

### Ma Raksha Mahotsava (Safe Motherhood Festival)

The *Ma Raksha Mahotsava* was held from October 1-6, 1998. Two-day camps were organized to provide women with diagnostic facilities and services for RTIs/STIs, for cancer and related problems, and to give tetanus toxoid (TT) immunizations to all pregnant women and adolescents within 10-16 years of age. Iron and folic acid (IFA) tablets, nutrition and health education for child rearing and breastfeeding, and immunization services were also provided. A maternity benefit of Rs. 300 was offered to all eligible pregnant women who attended the festival.

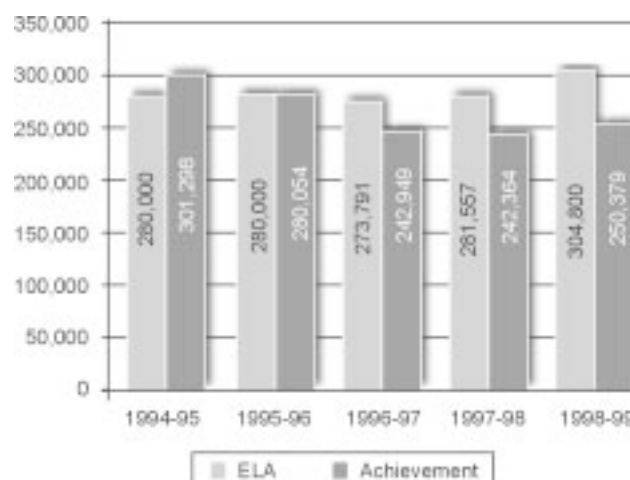
### Family Planning and RCH Performance 1994-99

#### Limiting Methods

Gujarat has performed very well in achieving sterilization targets over the past 10 years. In 1994-95 and 1995-96, the acceptance of limiting methods was 100 per cent or more of the sterilization targets allotted to the state. After implementing the TFA on an experimental basis in Valsad in 1995-96, overall acceptance dropped by seven percentage points compared to the previous year. Valsad reported a drop of 17 percentage points in that year.

The TFA was extended to all districts of the state in 1996-97. That year the state reported a decline of 12 percentage points in acceptance compared to that in 1995-96. The decline was about 20 per cent compared to 1994-95 levels. This was a significant drop in performance that can be directly attributed to the new approach. Acceptance consistently declined thereafter in 1997-98 and 1998-99 though the drop was marginal. The absolute number of sterilization acceptors was more or less constant from 1995-99 while the ELA increased marginally

Fig. 1  
Sterilization Performance in Gujarat



by 20,000 in 1998-99 compared to the base year 1996-97 (see Figure 1). Inter-district variation in acceptance was not significantly different pre-TFA and post-TFA/CNA.

Analysis of state data reveals a gradual and consistent reduction in the average number of children among couples who choose sterilization. The average for tubectomy acceptors declined from 3.11 children in 1995-96 to 3.05 children in 1997-98. It would seem, therefore, that the implementation of TFA/CNA increased acceptance by couples with lower parity. This is a welcome trend and indicates a change in programme philosophy in which providers are not under pressure to chase numerical targets. However, looking at the trends, one cannot attribute the reduction in parity of sterilization acceptors entirely to the new approach as the decline started before the new approach was introduced statewide.

### Spacing Method Performance 1995-99

Spacing method use constitutes about one-third of the reported contraceptive prevalence rate in the state; the remaining two-thirds consists of limiting method users. Traditionally, the state has performed very well in achieving spacing method targets. In

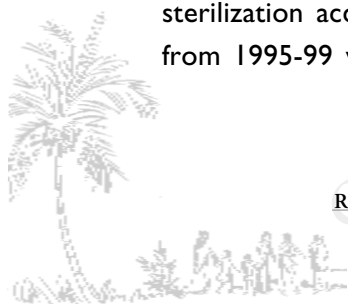


Table 1  
**Spacing Method Performance in Gujarat from 1994-99**

Year	IUD		Oral Pills		Condoms	
	ELA*	Per cent Achievement	ELA*	Per cent Achievement	ELA*	Per cent Achievement
94-95	460	103.0	165	108.50	925	139.70
95-96	460	98.30	165	104.80	948	116.62
96-97	467	87.61	170	94.19	948	107.14
97-98	472	85.05	197	82.19	895	92.08
98-99	472	87.54	200	86.49	1,000	88.99

\*Expected Levels of Achievement figures in thousands.

pre-TFA years, achievement was almost 100 per cent. In 1995-96, acceptance of IUDs was 98.3 per cent, acceptance of pills was 104.8 per cent, and acceptance of condoms was 116.6 per cent of annual state targets. When the TFA was implemented in Valsad in 1995-96, however, spacing method acceptors declined by 12 to 21 percentage points for IUDs, pills, and condoms.

The TFA was extended to all districts in 1996-97, and acceptance of spacing methods declined significantly thereafter. When compared with pre-TFA performance levels, IUD acceptance dropped by 10 percentage points in 1996-97, by 13 percentage points in 1997-98, and by 10 percentage points in 1998-99. Pill use declined by 10 percentage points in 1996-97, by 22 percentage points in 1997-98, and by 18 percentage points in 1998-99. Condom use recorded a decline of nine percentage points in 1996-97, 24 points in 1997-98, and 28 percentage points in 1998-99. State officials attributed this decline in spacing methods use to better reporting, which implies that earlier data were inflated and unreliable.

### **Trends in Mean Number of Children per Family Planning Acceptor**

The state set the ELAs for spacing methods for 1996-97 close to the targets allotted by GOI in 1995-96. The decline in acceptance during the first year of

implementation of the TFA was significant and was directly attributed to the new approach. In 1998-99, the ELAs were set at slightly higher levels. In terms of absolute number of users, acceptance of all spacing methods increased marginally, but due to the higher ELAs, the achievement in percentage terms declined compared to the pre-TFA period.

State officials were a bit cynical about the approach as far as target setting was concerned. They admitted that due to pressures from GOI, they had to insist on the achievement of the targets. The only difference was that the targets for the year 1994-95 were considered benchmarks for all subsequent years for setting ELAs and measuring performance. If the districts set targets using the TFA/CNA approach that did not match the benchmark targets of 1994-95, they were reviewed and revised accordingly by the state. The state sent the revised targets to the district and to GOI. Unlike the pre-TFA period, however, there seemed to be an element of leniency on the part of the officials monitoring family planning target achievement. They reportedly did not react very critically if achievement was not 100 per cent.

### **MCH Programme Performance**

One of the objectives of the TFA to family planning was to allow grassroot workers to concentrate on MCH activities. A perusal of Table 2 below indicates



that the achievement of targets set for selected MCH indicators like TT (among pregnant women), DPT/Polio, IFA (mother), and institutional deliveries has been consistently good in the state. However, regarding Vitamin A and IFA, the performance declined after the implementation of the TFA. Thus, it appears that the new approach has not yet improved the performance on Vitamin A and IFA indicators. Like the ELAs for family planning, the ELAs for MCH were also based on the benchmark targets of 1994-95.<sup>7</sup>

## Conclusion

The present review is based on discussions with state officials, district officials of Gandhinagar and Panch Mahal, and grassroot workers as well as on the analysis of official performance statistics. Indications are that Gujarat has been slowly gearing up to the new approach. Although one round of training was completed in 1997-98, sub-centre workers were not confident about estimating workloads and setting their own ELAs. Their supervisors often assisted them in preparing sub-centre plans. The study also indicates that the state insisted that the family planning targets of 1994-95 be used as benchmarks for setting ELAs under the TFA/CNA approach. Both state and district programme managers insisted that workers meet the ELAs during TFA/CNA implementation, but initial confusion and lack of understanding of the approach alongwith weak monitoring resulted in a

decline in performance for all indicators. This trend must be reversed or all the family planning/population control gains achieved in the past might be erased.

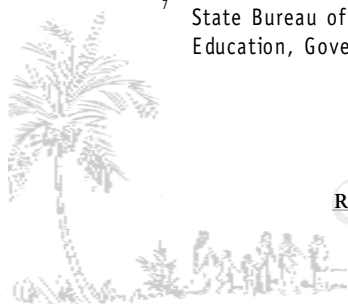
Regarding other RCH services, performance figures reveal that the shift in policy has yet to percolate down to the grassroots level even after almost three years. One of the reasons is a lack of necessary skills and comprehension of sub-centre staff.

State officials were quite enthusiastic about the introduction of the TFA/CNA approach. According to them, there was a qualitative improvement in acceptance of limiting methods of family planning in terms of a reduction in the age and parity of acceptors. Furthermore, they thought the use of the new approach yielded better data on the acceptance of spacing methods. They also felt that after the TFA/CNA approach was introduced, health workers were able to devote more time to MCH and other RCH services. Analysis of performance for 1995-99 does not, however, substantiate any of these claims. The trend of accepting limiting methods at younger ages and lower parities began prior to the introduction of the TFA/CNA approach, and it continued thereafter. If use of the approach resulted in better quality data on spacing method acceptance, then we must accept the fact that workers inflated earlier figures in fear of punitive action for not achieving targets. For other RCH services, the study

Table 2  
Percentage Achievement of ELAs in the MCH Programme in Gujarat

Year	TT (pregnant women)	DPT/POLIO	IFA	Vitamin A	Inst. Del.
94-95	96.9	99.7	122.7	95.9	37.1
95-96	94.6	98.8	103.4	87.4	34.0
96-97	93.2	97.3	86.8	79.0	36.9
97-98	94.8	97.9	87.0	79.0	40.0

<sup>7</sup> State Bureau of Health Intelligence, "Health Review of Gujarat 1995-96," Commission of Health, Medical Services and Medical Education, Government of Gujarat, Gandhinagar, 1997



did not show any appreciable increase in performance or in improvement of quality after the introduction of the TFA approach.

State officials identified high numbers of vacancies both in the administrative and technical staff at different levels along with difficulties in the flow of programme funds as factors that adversely affected the implementation of the RCH programme. Nonetheless, they were confident that in the current financial year, the programme will gain momentum and performance will reach pre-TFA levels.

The findings of this study suggest that the MOHFW pushed the implementation of the TFA ignoring both experiences in the experimental phase and state opinion. Furthermore, the approach was revised and changes were introduced frequently without adequate preparation and training support. The introduction of an innovation of this significance and scale perhaps warranted more intensive investment and support from GOI. The states should have been permitted flexibility in the timing and scope of implementation.

Efforts should also have been made to quickly transmit all the policy changes that occurred from

time to time. For example, the TFA was renamed the CNA approach, and planning and monitoring formats were revised. In the field, however, many of the doctors contacted during our field visits did not have any idea as to what alterations had occurred with the name change while the ANMs and supervisory staff had yet to hear about the CNA approach itself.

The use of information technology for the faster flow of information from field to state and vice-versa is a giant stride in the management of public health programmes. However, efforts made so far in this regard have been perfunctory. Alternative ways of monitoring and evaluating programmes are essential for making timely management decisions, especially when routine reports do not provide required or reliable data.

The introduction of an innovation of the nature of the CNA approach needs consistent support for a substantial period before it is internalized by the system. More intensive, regular training programmes should be organized, and supportive supervision should be strengthened until programme managers are confident that the majority of their health workers are conversant with the new approach.



# Community Needs Assessment Approach for Family Welfare in Karnataka



Ramakrishna Reddy  
P. Hanumantharayappa  
K.M.Sathyanarayana



## Background

Karnataka is one of the several progressive states in southern India. Even before independence it had moved to the forefront of the national family planning programme by establishing family planning clinics in Mysore and Bangalore in the 1930s which was the first official clinics in the country. The contraceptive prevalence rate 12 per cent in 1971 in the state. — increased to 55 per cent in 1998. The total fertility rate (TFR) dropped from 4.4 to 2.5 over the same period. Furthermore, there have been remarkable improvements in maternal and child health (MCH) indicators, especially in infant, child, and maternal mortality rates.<sup>1</sup>

Lately, however, family planning acceptance has remained more or less constant, and fertility levels have reached a plateau. There is also an enormous regional variation in the success of the programme. For example, while the divisions of Mysore and Bangalore are performing better than the state average, Gulbarga and Belgaum are not doing nearly so well. Major concerns include the availability of health facilities in rural areas and the often non-existent health structure in urban areas, vacant staff positions, and, more importantly, client accessibility to basic services. Realizing the need for improvement in these areas, the state has initiated several need-based projects. In the last five years, these

<sup>1</sup> Sample Registration System, Registrar General of India, 1998 and Population Research Centre and International Institute for Population Sciences, National Family Health Survey: Karnataka, Mumbai, 1995.





have included the Karnataka Health Systems Development Project, the KfW Project, India Population Projects VIII and IX, the Border Cluster Districts Project, and the Reproductive and Child Health (RCH) Services Project.<sup>2</sup>

The community needs assessment (CNA) approach, formerly known as the target-free approach (TFA), was introduced in 1995 on an experimental basis, in one district in accordance with the mandate of the Government of India (GOI). In the following year, again based on the decision of GOI, it was extended to all districts in the state. The way the state has gone about implementing the new approach from 1995 till the present and the modifications it has made in the process have been reviewed and documented.

The main objectives of this study are the following: (i) To describe the processes followed to implement the new system; (ii) To record the opinions of personnel at various levels on the new system and its implementation; and (iii) To analyze the potential effects of the new system on performance. Sample data were gathered in Mandya and Hassan districts from two primary health centres/community health centres/ PHCs/CHCs and four sub-centres. In addition, two PHCs that had an important role in executing the new approach were visited. Health personnel in the selected institutions were interviewed using broad guidelines prepared specifically for this purpose. All correspondence and other documents available at all levels from the Department of Family Welfare were collected and reviewed. Performance data were collected from the Directorate of Family Welfare and from districts as well.

## The Community Needs Assessment Approach

### Experimental Phase: 1995-96

The state became aware of the CNA approach in January 1995 after receiving a letter from the Secretary of Family Welfare, GOI. In the absence of any guidelines, state officers were not clear on just how to experiment with the new approach but, after a series of discussions, decided to try the new approach in one district. The criterion for selecting the district was consistent family planning performance. In addition, voluntary acceptance of family planning methods was given due consideration. Mandya was the obvious choice. Thus, in March 1995, the Additional Director for Family Welfare wrote the following to the District Health and Family Welfare Officer (DHFWO) in Mandya:

*“In the financial year 1995-96, the GOI is thinking of implementing the target-free approach in one district of the state on an experimental basis, and therefore we have decided to make your district target free. Emphasis will be on providing quality services and hence you will have to ensure it. You are, therefore, requested to work out your performance goals and work accordingly.”<sup>3</sup>*

There was no further communication from the state for several months. Neither the state nor the district made any effort to discuss guidelines for implementing the new approach though they could have done so at monthly state-level meetings. Meanwhile, as part of its normal routine, Mandya carried out the eligible couple (EC) survey and updated the eligible couple registers (ECRs). After conducting this exercise, district and block officers and field workers were informed of the new approach in a monthly meeting and in a letter, which stated the following:

<sup>2</sup> Human Development in Karnataka, Planning Department, Government of Karnataka, Bangalore, 1999.

<sup>3</sup> Letter from the Additional Director, Family Welfare, to Mandya district, March 1995.



*“During the year 1995-96, targets for the family planning programme have been removed. However, it is required that the workers should perform to the levels of last year.”*

Since the EC survey had already been completed, the district statistical officer collated the information and worked out the expected level of achievement (ELA) for each of the family planning methods. The yardstick for monitoring the performance of field workers was the previous year’s performance and the performance in that particular month.

In August 1995, the first guidance on the implementation of the new approach arrived in the form of a letter from the Secretary of Family Welfare, GOI, to the State Secretary. It read as follows:

*“As you are aware, an important decision was taken in the meeting of the state secretaries in charge of family welfare on April 3 and 4 1995, to exempt at least one district from the contraceptive targets.*

The objective of exempting one district from targets was to improve the quality of services. To carry this message down to the grassroot workers, it would be necessary to sensitize the district level officers, the PHC Medical Officers (MOs) and the health workers on specific aspects of quality improvement and the steps to be taken in this regard. Such sensitization could be done during (i) monthly meetings of district level officers at state headquarters; (ii) meetings of PHC MOs at the district level; and (iii) meetings of male/female health workers at the PHC level. You may identify resource persons for conducting such sensitization of all personnel in the target-free district/areas.

The Government of Tamil Nadu has recently issued detailed instructions on the MCH approach to family planning and specific services that will be quantified and monitored. I am sending herewith a copy of the order issued by the Tamil Nadu government in this regard. This is an interesting experiment worth emulating.

We propose to conduct a concurrent evaluation of programme performance in the target-free districts/ areas through Population Research Centres. The concurrent evaluation will also study the qualitative improvement in services.

May I request you to take suitable steps to improve the quality of services in these district/areas and apprise me of the action taken.”<sup>4</sup>

State officials in Karnataka reviewed the order mentioned and decided that the Tamil Nadu approach did not add anything worth considering. The state, therefore, did not inform the district of its contents nor did it make any effort to understand the implementation mechanism described therein.

Overall, family planning performance in Mandya in 1995-96 was more or less consistent with 1994-95. Sterilization and IUD acceptance definitely increased, but there was a decline in the use of oral pills and condoms. It would appear, therefore, that the only effect that the CNA approach had on the family planning programme was that the district worked out its own “targets” for the first time ever. However, it can be inferred that the new approach was not field-tested in the real sense because the district did exactly what it had been doing previously to work out ELAs. In contrast, there was substantial improvement in MCH indicators as more

<sup>4</sup> Letter from the Secretary, Family Welfare, GOI, addressed to the State Secretary of Karnataka, August 1995.



women received antenatal (AN), natal, and post-natal care. Immunization coverage for infants improved as well.

## **Expansion of CNA**

The decision to expand the CNA approach was made in a meeting of State Secretaries in New Delhi on February 1 and 2, 1996. Without deliberating on the experiences of various states in the experimental year and despite strong opposition from many of them, GOI announced its plans to extend the approach to all districts in the country. Since the new approach had not really been tried out in Karnataka, and the officials present at the meeting were not aware of the methodology Mandya had used during the experimental year, they did not oppose the government's decision. In general, however, they thought that it would be difficult for field workers with limited academic qualifications to comprehend the approach and that the process of change from targets to target-free would require a considerable amount of time and a substantial obligation of resources. GOI insisted that the new approach would improve the quality of services and stated that proper guidelines and an implementation manual would be prepared and given to all states.

Subsequently, the Secretary of Family Welfare, GOI, wrote to all State Secretaries on February 14, 1996, about the use of the CNA approach in the family welfare programme. It stated the importance of the new approach, proposed the methodology for preparing plans at various levels of the service delivery system, and mentioned that the new approach would provide an excellent opportunity to make family welfare in India a truly people's programme.

The letter outlined the procedure for preparing plans in the following manner:

*"A draft format for the PHC plan as is being used in Tamil Nadu, circulated in the February meeting as part of the agenda notes, may be used. You may like to initiate this exercise of involving all health personnel, village pradhans, primary school teachers, and NGOs working in each PHC in your state on the basis of this format or with such modification to it as you deem necessary. A detailed format for preparing the PHC/ FWHC plan is under preparation at our level and could be made available before the end of March 1996. However, the preparation of your FW and health care plan need not wait for this data format. The performance of each PHC would need to be evaluated against its own plan by the district health and FW system at the end of each quarter to advise them suitably. They would also need to tune the IEC activities in the PHC area and districts to prompt this bottom-up approach of planning and implementation of a sensitive programme like family welfare.*

*All the PHC FW plans would need to be aggregated into the district FW plans and the district FW plans would similarly need to be aggregated in the state FW plan. A timetable for preparation of the plans at various levels may be set. I would suggest that the PHC plans may be finalized by April 30, 1996, the district plans by May 15, 1996, and the state plans by May 31, 1996. We would like to have your state FW plan by the first week of June 1996.*

*A system of evaluating the performance of each district every quarter may be worked out at the state level. A similar exercise to evaluate the performance of each state would be carried out at the national level. This exercise would need sensitization of the entire health and family welfare organization in the state with the deputy commissioners/ district magistrates playing a leading role along with the district health and FW system in active collaboration with*



*panchayati raj dignitaries, primary school teachers and active NGOs.”*<sup>5</sup>

The state directorate forwarded the Secretary's letter to all DHFWOs and asked them to follow the instructions carefully. However, before the February letter from GOI reached the districts, the district magistrates received a different letter sent directly from the GOI Secretary of Family Welfare dated March 4, 1996.<sup>6</sup> In it, the Secretary discussed sensitization workshops, the budget for conducting them, and a set of guidelines. The budget for sensitization was released to the districts on an average basis without considering the number of PHCs and had to be collected from the regional director's office. The state was unaware of the March-letter and, surprisingly, none of the districts reported it. On April 4, 1996, the Joint Secretary of Family Welfare, GOI, wrote a letter to the State Secretary about the sensitization workshops with a copy of the March 4, letter attached.<sup>7</sup> The state later corresponded with the regional director and determined the exact budget for each district. One-day sensitization workshops at the state, district, and block levels were ultimately conducted between July and September 1996, for all health personnel, representatives of NGOs, members of panchayati raj institutions (PRI), anganwadi workers (AWW), and National Swayam Sewika (NSS) volunteers.

The GOI sent a detailed plan of the bottom-up approach to all states on March 27, 1996. After reviewing it, Karnataka felt that the districts should follow the government's instructions exactly and should estimate perceived needs and service

requirements. The GOI data collection format included 17 questions on antenatal care (ANC), deliveries, post-natal care, immunization of children, acute respiratory infections (ARI), diarrhoea in children, and family planning. The GOI coverage norms were tagged to these indicators with the exception of those for family planning. The states were advised to prescribe their own family planning norms to arrive at total service requirements. The format provided an idea of the magnitude of the task of restructuring demand for reproductive and child health (RCH) services and family planning in terms of perceived needs instead of as a function of the previous year's performance.

### **The Implementation of the CNA Approach**

Traditionally, data collected annually in the ECRs were to be used for working out MCH and family planning targets; however, because targets were set by the state, this locally gathered information was rarely used. With the introduction of the CNA approach, however, the state expected that ECR data would become quite valuable. Hence, the districts were asked to collect the data and use the GOI-prescribed coverage norms to arrive at the ELA for various MCH indicators. These calculations were simplified by uniformly applying a birth rate of 19 per 1,000 population, despite the enormous regional variations within the state.

As there were no specified norms from GOI for calculating family planning ELA, the state used its own methodology. Districts were instructed to calculate the ELA on the basis of the perceived need or the

<sup>5</sup> Letter from the Secretary, Family Welfare, GOI, addressed to the State Secretary in February 1996 and subsequently marked to the districts March 1996.

<sup>6</sup> Letter from the Secretary, Family Welfare, GOI, addressed to district collectors/magistrates March 1996.

<sup>7</sup> Letter from the Joint Secretary, Family Welfare, GOI, marking the letter addressed to district collectors/ magistrates to the State Secretary April 1996.



unmet need. This led to confusion because the ECR Survey Format-HMIS Version 2.0, did not capture information on unmet need for family planning but nevertheless the state sent a letter to the districts. In the absence of a clearly stated methodology, the districts were informally asked to consider past performance while formulating their activity plans. A few districts considered only the previous year's performance while other districts considered the average of the past three years. Thus, there was no uniformity among districts in the preparation of activity plans. Nevertheless, the state had introduced

---

The implementation of the CNA approach in the first year of the expansion phase was limited to state and district officers only.

This resulted in enormous confusion as they interpreted the TFA in various ways and calculated the ELA for family planning methods to suit themselves.

---

the new approach, and the activity plans that were prepared by health functionaries were consolidated at the PHC, district, and state levels. A state-level plan was prepared and submitted to GOI by July 1996. State officials monitored progress in the preparation of the activity plans.

Although the activity plans were ready by the end of July 1996, staff orientation and the translation of the GOI manual

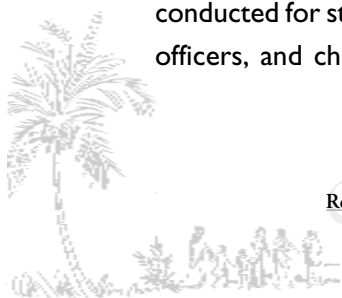
into the local language had yet to be done. No effort was made to do either as a result of a delay in delegating responsibility to officers at the state level. In September 1996, the GOI organized a two-day CNA orientation workshop in New Delhi for state officers to discuss the various terms and definitions used in the manual. Three officers from Karnataka participated; on returning to the state, they were given the task of conducting orientation training for all health personnel.

In November 1996, a 10-day training session was conducted for state and DHFWO, senior programme officers, and chief executive officers (CEOs) of the

Zilla Panchayats. (since Karnataka had already implemented the Panchayati Raj Act, the CEOs had assumed the role hitherto played by the district magistrates and were the chairpersons of the district health committees where public health and family welfare came under their purview. They were, therefore, included in order to familiarize them with the recent changes in the family welfare programme). The session focused on the roles and responsibilities of the district health committee, the essence of the manual, and the monitoring and compilation of progress reports. Also, a detailed plan for training staff was outlined. Trainers at district levels and below were identified from among the health officers attending, and a workshop itinerary was prepared. To facilitate training, state officers were assigned to districts. A 10-page booklet in the local language that outlined the concept of CNA and explained the methodology for estimating ELA was circulated to all the participants.

Thus, the implementation of the CNA approach in the first year of the expansion phase was limited to state and district officers only. This resulted in enormous confusion as they interpreted the TFA in various ways and calculated the ELA for family planning methods to suit themselves. This practice continued into the next half of the fiscal year until all remaining health professionals and functionaries were trained.

In the latter part of 1997-98, the state finally began district and *taluka* level training and continued it until the end of June 1998. All health personnel, members of PRIs, child development officers, and AWWs were trained in these workshops, but in fact, the family welfare programme for 1997-98 had already been implemented. The activity plans and progress reports that had been introduced along with the new approach were already operational, and the sub-centres had already collected information according to the



prescribed formats that had been compiled at various levels to represent PHC, district, and state plans. Training should have preceded implementation, as it didn't, the health department had already implemented the CNA approach without understanding the concepts underlying the approach.

In 1998-99, the districts in which CNA training had been completed followed the procedures learned in the training sessions while other districts prepared plans based on the previous year's methodology. Also around this time, the birth rate previously used to calculate MCH indicators was revised from 19 to 18 per 1,000. This figure once again was uniformly applied—irrespective of the actual birth rate of the district. It is difficult to understand how the state arrived at this figure when the sample registration system for those years reported much higher rates. Due to the variety of methodologies being applied, confusion prevailed especially in the family planning programme.

During this time, GOI modified the new approach by revising the formats used to make activity plans and progress reports. The number of formats was reduced drastically from more than 30 to nine,<sup>8</sup> but Karnataka continued using all the old formats to avoid further confusion at the field level since the workers were reconciled to them. State officials introduced the new formats only at the PHC level and above, after conducting four regional workshops in Bangalore, Belgaum, Gulbarga and Mysore with financial assistance from UNICEF. In addition, two workshops, one in 1998 and the other in 1999, were conducted for statistical assistants. MOs and statistical assistants then started compiling information using the newly introduced formats, so their reports to GOI changed accordingly.

Due to the delay in training of lower-level health staff, the new approach could not be implemented in the true sense. GOI was unaware of this. As the state submitted activity plans and progress reports to GOI on time, the government presumed that the new approach was working well and that health personnel had understood the concept and were implementing it correctly. This practice of evaluating performance solely on the basis of the timely submission of forms did not bode well for the transition from targeted to target-free programmes.

## Experiences in Implementing the CNA Approach

Health personnel from the selected districts, PHCs, and sub-centres were interviewed about the CNA approach. The processes followed and opinions given are summarized below.

The general feeling at the district level is that the new approach is a welcome change from top-down targets as it makes field workers more responsive and responsible. The methodology proposed by GOI is being followed along the suggested guidelines, and it seems to be working well. Instead of the state setting 'targets,' the districts set them through a consultative process. The feeling is that the approach is more useful than top-down target setting due to the participation of all staff in the process. The confusion that prevailed when targets were removed has given way to a more confident approach to programme implementation. Monitoring at the PHC and sub-centre levels has become easy.

---

The general feeling at the district level is that the new approach is a welcome change from top-down targets as it makes field workers more responsive and responsible. The methodology proposed by GOI is being followed along the suggested guidelines, and it seems to be working well.

---

<sup>8</sup> Letter from the Secretary, Family Welfare, GOI, addressed to the State Secretary January 1998.



The DHFWO of Mandya district explained that despite initial fluctuations, the district has been able to maintain its performance levels. Even though acceptance of sterilization has dropped, the decline is insignificant compared to that elsewhere in the state. In this context, he stated the following:

*“The interesting aspect in the district is that it is immaterial to people what approach the district is following because people over here come voluntarily for family planning services and demand quality services. Providing quality services is the major concern, and we at the district have taken measures to assure this.”*

---

The auxiliary nurse midwives (ANMs) enthusiastically claimed that the CNA approach is better than the one with targets imposed from above. They explained that their task is now defined by benchmarks derived from the prevailing birth rate in their sub-centre areas instead of by targets based on population size.

---

Having said this, he informed us that the district has adhered to all instructions received from the GOI and has executed the programme accordingly. Although there were delays in training staff, efforts have been made to make them thoroughly understand the new approach. The concept of the CNA approach has been constantly reiterated in monthly meetings, and that has paid off. All staff members are aware of CNA and have participated in the preparation of the activity plans

after discussing them with panchayati raj members and AWWs. The statistical assistants have played an important role in the compilation of the forms and in monitoring and have been the major link between the programme officers and the field workers. The DHFWO of Hassan district expressed similar views.

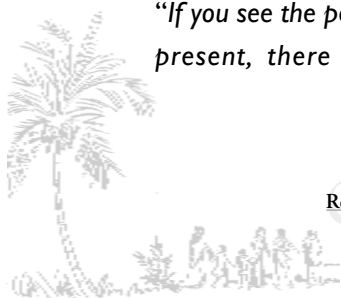
Regarding family planning performance and the strategy of identifying perceived needs, both DHFWOs agreed:

*“If you see the performance of the past few years and at present, there is nothing wrong in admitting that*

*performance has remained more or less the same, but if the age and parity of acceptors are analyzed, they have come down considerably, and this is a positive sign for the programme. Even now there is no clarity on how the ELAs for family planning methods have to be arrived at. Based on past performance, the ELAs are being worked out. This methodology will not address client needs and hence a methodology that can look into this aspect should be developed and implemented.”*

They also mentioned that leadership at the local level, commitment of staff, and close monitoring of the programme were key factors to success and that their districts had been able to exhibit all of those characteristics. This was found to be true because the MOs of PHCs, who were knowledgeable about the CNA approach were able to provide direction to the programme. They had definite time slots for reinforcing the concept in monthly meetings, and therefore, the supervisory staff and sub-centre functionaries in their PHC areas had a clear understanding of what was expected of them. On the contrary, in PHCs in those districts where the commitment of the MO was weak, the understanding among staff members of the approach and its implementation was also weak. It was agreed that one-time training without constant reinforcement would not have much effect. This was demonstrated in the PHCs where the MOs lacked proper understanding.

The auxiliary nurse midwives (ANMs) enthusiastically claimed that the CNA approach is better than the one with targets imposed from above. They explained that their task is now defined by benchmarks derived from the prevailing birth rate in their sub-centre areas instead of by targets based on population size. However, regarding the use of birth rates for calculations, one of the ANMs remarked:



*“In my area, the birth rate seems to be less than that proposed by the district or state. By applying this rate, the workload in my area gets over estimated, and it becomes difficult to achieve the ELAs. In spite of complaining about it, the medical officer has not been able to resolve the problem, and I am told that in the next year, we will try to work out something on the basis of which the calculations will be done. I think some alternative has to be developed or else the present approach will end up as a target-driven approach given in a different way. The pressure to perform still continues and temporary denial of salary/pecuniary benefits is recommended if the self-determined ELAs are not met.”*

Other ANMs endorsed this view as well.

The review team discussed these perceptions from the field with the Additional Director, who is also the RCH programme director and has been associated with the CNA approach since its inception. The Additional Director said the following:

*“The new approach has a sound methodology and has a good philosophy associated with it. Although I was not convinced in the beginning, I developed a liking after I understood the concept of it thoroughly. For a person at my level it took some time, and you can imagine how much time and effort are required to change the mind-set of the health functionaries at the grassroot level. Proper training of functionaries supported by a well-equipped service delivery system form the essential ingredients of the programme. The only apprehension I had then, and I still have, is that the GOI hurriedly pushed the implementation of the new approach without paying much heed to training and strengthening service delivery systems.”*

The state was tasked with the implementation of the new approach, but it had not readied its resources. There were delays on all fronts. In the beginning, state officials did not have a clue about CNA as the training of master trainers had not taken place

because funds were not released on time. In this context, it was difficult to implement something they were not confident about. Moreover, Karnataka’s family planning programme performance had slipped. The fertility rate that was once comparable with those of the neighbouring states of Andhra Pradesh and Tamil Nadu had stabilized while the rates of the other states had moved closer to or had reached replacement levels. The Additional Director, therefore, remarked:

“With very little improvement in performance over the past few years, I feel that Karnataka has become the BIMARU (sick) state of South India. The state, unlike Andhra Pradesh, lacks political will and commitment at all levels, and that has resulted in inordinate delays in decision-making that have hampered the programme and its performance.”

---

In order to maintain the tempo of family planning acceptance, the state must closely monitor the age, parity, and education levels of acceptors of sterilization and IUDs. The pressure on workers to perform remains despite the new methodology.

---

Hence, nothing new was attempted except for sharing the monitoring and activity formats to satisfy the immediate needs of GOI. All health personnel have since learned how to estimate ELA, yet the state still lacks a clear-cut methodology for addressing client needs. To help solve the problem, birth rates of 19 and subsequently 18 per 1,000 were used to calculate indicators throughout the state in spite of well-documented regional variations. The technique of surveying 100 mothers proposed as part of the approach was also tried out, but it did not give a clear indication of client needs.

In order to maintain the tempo of family planning acceptance, the state must closely monitor the age, parity, and education levels of acceptors of sterilization and IUDs. The pressure on workers to perform remains despite the new methodology. The





Additional Director was happy that in most regions of the state acceptance was voluntary, though that is not always the case in the northern part, where lower levels of acceptance have negatively affected the state average. In regard to lagging performance, the Additional Director was optimistic and said this:

*“With more efforts by the Department, the state can surge ahead in the RCH and family planning programmes. Even though there are regional imbalances in the northern parts of the state, various innovative projects and schemes have been initiated, but it will take time before these districts yield the fruits of the interventions.”*

The state demographer added these comments:

*“The statistical assistants have done an excellent job in carrying the message of the new approach down to the grassroot level. In the first year, in the absence of proper training, the responsibility for compiling the GOI forms was entrusted to them. In the subsequent year, they played an active role and were able to impart the necessary working knowledge to the ANMs. Scrutinizing, compiling and timely monitoring of activity plans were all done by them.”*

When asked about orienting health workers to the newly introduced forms, the state demographer said that Karnataka intends to do so as part of the overdue RCH training. Furthermore, the concept of unmet need will be taught, and the ECRs will be revised to include questions related to the estimation of unmet

need. The ELAs for each method will be worked out on the basis of data collected in these ECRs.

In the light of these discussions, it can be inferred that Karnataka did make efforts to help workers understand the new concept, but discussions with health functionaries revealed that the pressure to perform, especially in sterilization, had actually increased.

## Family Planning Performance

### Limiting Methods

The annual acceptance of sterilization steadily increased in Karnataka from 371,535 in 1994-95 to 395,624 in 1997-98. However, in 1998-99, when the state actually implemented the CNA approach by training all field workers, acceptance dropped by six per cent from the previous year.

Sterilization acceptance in 1998-99 was comparable with the level of 1994-95. In other words, the decline in acceptance was marginal because the pressure to achieve ELA in sterilization has been maintained since the introduction of the new approach. The state claims to have taken measures to closely monitor the age, parity, and education of acceptors and notes that there has been a slight drop in the average age and parity for women. State officials are confident that if pressure on performance in general and on sterilization in particular is maintained, the state will be able to achieve better results in the years to come.

Table 1  
**Expected and Actual Level of Sterilization Performance in Karnataka from 1994-95 to 1998-99**

Year	Annual Performance	Percentage Increase/ Decrease Over the Past Years Performance
1994-95	371,535	***
1995-96	381,571	2.7
1996-97	384,056	0.7
1997-98	395,624	3.0
1998-99	371,275	-6.2



### Spacing Methods

The National Family Health Survey (NFHS) in 1992 found that in Karnataka, only one-tenth of modern contraceptive-users were using a spacing method. With over a third of the population in urban areas, the percentage of spacing-method use to total use is quite small. The state realizes the strong potential demand for spacing methods and is making a considerable effort to promote them by way of rigorous marketing, IEC campaigns, and area-specific interventions. Yet the levels as reported in the service statistics have not increased as expected. The performance in the last five years in terms of the percentage increase/decrease for each spacing method is summarized in Table 2.

### IUDs

Acceptance of IUDs in the last five years has increased by 13 per cent; however, the pattern of increase has not been consistent. In 1994-95, there were 299,504 acceptors; that number rose to 345,937 in 1995-96, an increase of over 15 per cent. In the following year, acceptance increased by another nine per cent. It then declined by one per cent in 1997-98, and by nine per cent in 1998-99. This is a matter for concern. Unless the state takes proper measures, it will be difficult to sustain the present level of use and to motivate new acceptors. The state is now monitoring retention rates. Those rates will give a

better idea of the number of births averted, which can have a considerable impact on reducing fertility.

### Oral Pills

The common practice for setting the ELA for oral pills is in terms of the number of users. Performance records at the district and lower levels, however, provide information in terms of the number of cycles distributed. That number is aggregated at the state level and divided by 13 cycles to get the number of users. In other words, the calculations are restricted to distribution numbers without considering vital information on continuation rates. Oral pill acceptance has been similar to that of IUDs except for the fact that the extent of decline in acceptance has been smaller. Following the introduction of the new approach by the state in 1997-98, performance declined marginally; in 1998-99 it dropped by five per cent. Overall, however, acceptance increased by eight per cent during the reference period.

### Condoms

The calculation of condom-users is based on a methodology similar to that used for determining oral pill-users, and identical problems exist. The annual number of users is arrived at by dividing the number of condoms distributed by 72. Unlike other spacing methods, condom-use in Karnataka has been declining steadily since 1994-95. In that year, there were 395,108 users. In the following year, the total

Table 2  
Annual Performance and Percentage Increase/Decrease of Spacing Methods in Karnataka from 1994-95 to 1998-99

Year	IUD		Oral Pills		Condoms	
	AP	PI/PD	AP	PI/PD	AP	PI/PD
1994-95	299,504	***	138,232	***	395,108	***
1995-96	345,937	15.5	151,145	9.3	374,687	-5.2
1996-97	376,247	8.8	157,545	4.2	358,627	-4.3
1997-98	372,341	-1.0	156,494	-0.7	323,021	-9.9
1998-99	337,854	-9.2	148,931	-4.8	278,626	-13.7

AP= Annual Performance; PI/PD= Percentage Increase/Percentage Decrease over the past year



declined by five per cent. After that, the decline was much greater until in 1998-99, condom-use had fallen to 70 per cent of what it was in 1994-95.

## Sterilization Equivalents

In order to provide a more holistic picture of programme performance, Karnataka routinely reports to GOI on sterilization equivalents as well as on the annual acceptance of each family planning method. Sterilization equivalents are calculated by combining sterilizations with spacing methods according to the following formula, supplied by GOI. **Sterilization Equivalents = Sterilizations + 1/3 the number of IUD insertions + 1/8 the number of condom-users + 1/9 the number of oral pill-users.** The results of this calculation for Karnataka are shown in Figure 1. All spacing method users are converted in this way and are added to actual sterilization statistics. The state has placed more emphasis on both limiting and spacing methods, but the pressure to increase the number of sterilization acceptors is greater.

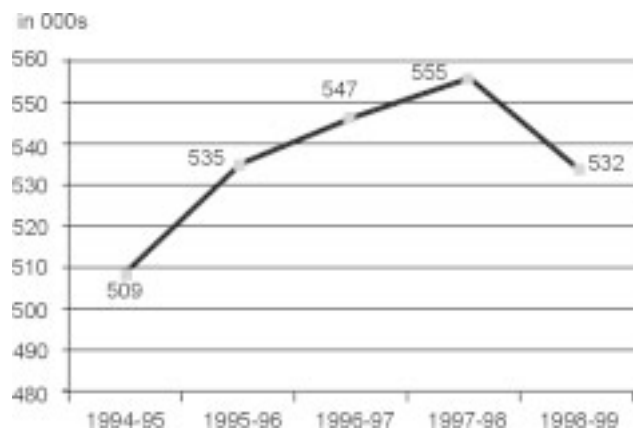
An analysis of sterilization equivalents reveals that performance has been reasonably good. Acceptors increased from 509,000 in 1994-95 to 555,000 in 1997-98. In 1998-99, after the introduction of the CNA approach, the number dropped to 532,000,

which was the performance level in 1995-96. In 1997-98, however, despite a decline in spacing method acceptance, the number of sterilization equivalents rose substantially, due mainly to increased sterilization acceptance.

If the state intends to monitor performance through sterilization equivalents, then the quality of data on spacing methods needs to improve. The number of regular users, the duration of use, and continuation rates for each spacing method will have to be collected and analyzed. To do this, monitoring formats will have to be redesigned. If not, inferences drawn from the existing data will be misleading.

Family planning service statistics clearly indicate a decline in performance for spacing methods since the effective introduction of the CNA approach, even though the acceptance of IUDs and oral pills increased over the five-year period. State officials attributed some of the decline to poor infrastructure in the northern region of the state but put the majority of the blame on CNA and the confusion that resulted from its introduction. Yet, there is still optimism at the state level because of various innovative interventions that have been undertaken.

Fig. 1  
Sterilization Equivalents in Karnataka



## Performance in Reproductive and Child Health

The family planning programme suffered from the CNA approach because there was no clear system for working out method-specific ELA. This was not the case for RCH indicators. ELA could easily be calculated by applying the state-determined birth rate to the GOI coverage norms. The result was performance better than the expected levels. In 1999 for instance, the coverage for ANC and child immunizations including DPT, polio, and measles was higher than the proposed levels. As a matter of fact,



the performance in RCH indicators improved over the previous year, and the infant mortality rate (IMR) in 1998 was 58 as compared to the national average of 72. Thus, overall performance in RCH seems to have improved considerably, but before drawing such an inference it is worthwhile to examine the GOI coverage norms and the birth rate used. The norms were generalized at the national level and the birth rate which the state used was low. Those two factors together could have resulted in underestimation of the ELA, thus, allowing achievement levels of more than 100 per cent to be reached.

## Conclusion

Karnataka has made efforts to implement the CNA approach in light of the guidelines provided by GOI. Due to a delayed start, however, the approach could not be field-tested in the true sense for over a year and a half. When the health system was ready to absorb the new concept and implement it, GOI modified the existing data collection formats. MOs and assistant statistical officers were reoriented in their use, but field workers were not. The central government's monitoring of the implementation of the new approach in both the original and revised forms consisted solely of logging in the monthly reports that the state regularly submitted. Due to this, GOI failed to understand what was really happening.

Although the state did not impose any targets on the districts, there was no clearly defined system for setting ELA for family planning methods, so confusion about their calculation was widespread. There was a system for working out ELA for RCH

indicators, though calculating coverage norms—based on a standardized birth rate lower than the actual one that further ignored regional and district variations—defied the very principles of bottom-up planning. Furthermore, although RCH ELA were set at the sub-centre and PHC levels, no effort was made to use the ECR data, and no thought was given to modifying the registers to capture missing information.

In the past five years, the overall number of family planning acceptors generally increased, but after the state implemented the CNA approach at the field level, acceptance rates began to fall. The extent of the drop in the rates for spacing methods was considerable. Although the state is monitoring acceptance independently and in terms of sterilization equivalents, continuation rates for oral pills and condoms and retention rates for IUDs have to be analyzed.

The RCH programme begun in 1997 is not yet operational at the field level. The concept of the CNA approach must be integrated into the RCH training package and the ECRs must be modified to capture unmet need. The state needs to meticulously plan the integration process based on a long-term goal. In the absence of it, the state will find it difficult to implement bottom-up planning and to increase performance levels.

---

Karnataka has made efforts to implement the CNA approach in light of the guidelines provided by GOI. Due to a delayed start, however, the approach could not be field-tested in the true sense for over a year and a half.

---



# Community Needs Assessment Approach for Family Welfare in Madhya Pradesh



Ashok Das  
K.M. Sathyanarayana



## Background

Madhya Pradesh covers 14 per cent of the total land area of India, which makes it the largest state in the country. It ranks sixth in terms of population and 22<sup>nd</sup> in terms of population density among India's 32 states and union territories.<sup>1</sup> It is divided into 61 districts, each of which is subdivided into 12 administrative divisions. According to the 1991 census, the population of the state was 66 million, three-fourths of which was concentrated in rural areas. The population density was 149 persons per square kilometre compared to 274 for the country as a whole. The sex ratio was 931 females per 1,000 males. Over 40 per cent of the population is literate: nearly 60 per cent of males but only 29 per cent of females are literate. Scheduled Castes and Scheduled Tribes constitute 40 per cent of the population. In general, the age at marriage of females is less than the legal age of marriage.<sup>2</sup>

Agriculture is the single largest sector of the economy employing over three-fourths of the labour force. It accounts for half of the income of the state.<sup>3</sup> Major agricultural products include wheat, rice, *jowar*, *bajra*, sugar cane, maize, cotton, groundnuts, gram, and *tur*. The state is self-sufficient in the production of food grains. The annual rate of increase in food grain production in the last two decades was 2.2 per cent.<sup>4</sup>

<sup>1</sup> "Madhya Pradesh Population Policy," Government of Madhya Pradesh, 2000

<sup>2</sup> National Family Health Survey: Madhya Pradesh, Population Research Centre and International Institute for Population Sciences, Mumbai, 1992

<sup>3</sup> Directorate of Economics and Statistics, Government of Madhya Pradesh, 1992

<sup>4</sup> Centre for Monitoring Indian Economy, Mumbai, 1991



Madhya Pradesh is less developed in terms of industry when compared with other states in India. Jute goods, cement, sugar, newsprint, and *vanaspati ghee* are the main industrial products. Except for Bharat Heavy Electricals Limited in Bhopal and the Bhilai Steel Plant in Durg, there are no major industries. Nevertheless, the state is making rapid strides in the production of cotton, leather goods and aluminium.

The human development index (HDI) of a state provides an overall picture of its social and economic status. In Madhya Pradesh, it is very low; in fact, when compared with other states of the country, it

Although population size has increased alarmingly, the total fertility rate in MP declined from 5.6 in 1971 to 4.0. During this period, the contraceptive prevalence rate increased from 10 to 42 per cent, which contributed to the decline in fertility.

is only slightly higher than that of Uttar Pradesh which has the lowest HDI ranking.<sup>5</sup> The proportion below the poverty line declined from 62 per cent in 1977-78 to 42 per cent in 1993-94, yet the actual number of poor remained constant at 30 million persons. Infrastructure in the state is inadequate and hence many villages are inaccessible. In fact, *pucca* (all-weather) roads

connect only 23 per cent of villages. The percentage of households with basic facilities such as electricity, safe water, and toilets varies from 3 per cent in Rajgarh district to 41 per cent in Indore. Furthermore, there are considerable variations among districts in almost all demographic, social and economic indicators. Almost half of all villages in the state (71,526) have fewer than 500 inhabitants, although this proportion varies from 29 per cent of the villages in the district of East Nimar to 66 per cent in Rajgarh.

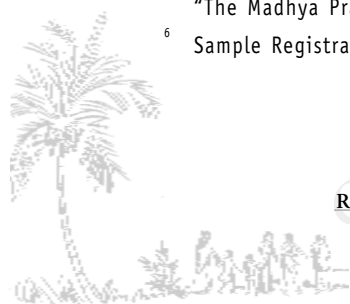
The population of Madhya Pradesh nearly doubled from four crores in 1971 to seven crores in 1997 (1 crore = 10,000,000). It continues to grow by over 15 lakh per year, at an average rate of 2.2 per cent per annum (1 lakh = 100,000). The state's population reached its first crore in 1821; after that it took 104 years to reach its second. At the current rate of growth, it takes only seven years to add another crore to the population. The population has increased so rapidly because declines in mortality outpaced declines in fertility. The birth rate that was over 45 in 1951 dropped to 30.6 in 1998. Similarly, however, the death rate dropped rapidly from around 30 to 11.2, and infant mortality fell from over 150 to 97 during the same period.

Although population size has increased alarmingly, the total fertility rate in Madhya Pradesh that was hovering around 5.6 in 1971 declined to 4.0 in 1997.<sup>6</sup> During this period, the contraceptive prevalence rate increased from 10 to 42 per cent, which contributed to the decline in fertility. Given the poor social and economic environment and the total dependence of the population on public sector institutions, a reduction of over 1.5 children per woman in a period of three decades is a major achievement for the family welfare programme in the state.

Regarding the health status of mothers and children, however, there is great need for improvement. The percentage of children aged 12-23 months who have received any vaccinations increased from 62 per cent in 1992-93 to 80 per cent in 1998-99 in rural areas, and from 80 per cent to 94 per cent in urban areas. While immunization services have successfully reached more children than six years ago, the proportion of children receiving all required doses of

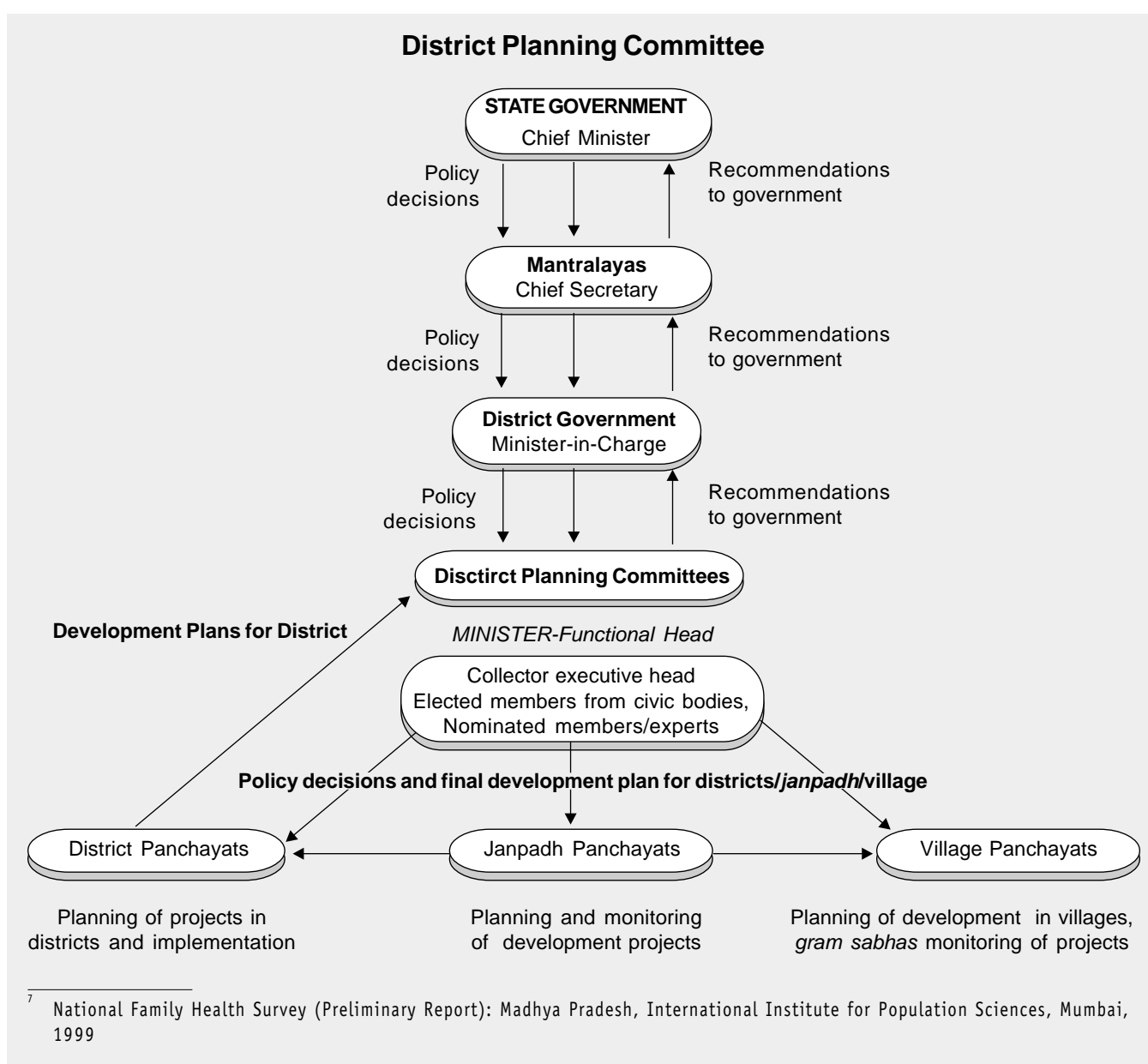
<sup>5</sup> "The Madhya Pradesh Human Development Report," Planning Department, Government of Madhya Pradesh, Bhopal, 1998

<sup>6</sup> Sample Registration System, Registrar General of India, 1998



all vaccines has not shown appreciable improvement. The proportion of pregnant women who obtained antenatal care (ANC) services increased from 52 per cent in 1992-93 to 62 per cent in 1998-99. It is interesting to note that during this period, only 22 per cent of deliveries in the state were institutional deliveries and of these, two-thirds occurred in private health institutions. Trained personnel assisted less than one-third of all deliveries. Skilled personnel such as doctors, midwives and trained *dais* (traditional birth attendants) attended an additional 20 per cent of births

at home. Over two-thirds of births in rural areas and one-seventh of births in urban areas occurred at home, attended by traditional birth attendants (TBAs) who are often untrained and work in unhygienic conditions.<sup>7</sup> It is not surprising that the maternal mortality in the state is among the highest in the country, at 498 mothers dying per 100,000 live births. Thus, from the point of view of per capita income, literacy, urbanization, infrastructure, facilities in general, and health facilities in particular, Madhya Pradesh belongs to the category of less-developed states of India.



## Democratic Decentralization

In an effort to accelerate the pace of development in the state, Madhya Pradesh initiated the process of democratic decentralization. The 73<sup>rd</sup> and 74<sup>th</sup> constitutional amendments passed by the Indian Parliament in 1992 enabled decentralized government through *Panchayati Raj* Institutions (PRIs) in rural areas and local urban bodies in urban areas. Madhya Pradesh was the first state to conduct elections to PRIs and devolved significant authority and responsibility in letter and spirit to the elected bodies. In 1995-96, the state transferred 18 development departments, critical to the improvement of living conditions of rural people,

to different layers of the PRIs, including education, health and family welfare, and women and child development among others.

To accelerate the process of decentralization and make it more effective, in 1999 the state government passed the DPC Amendment Bill in the assembly. Under the new system, many powers of the state government were decentralized and delegated to recently created DPCs.

To accelerate the process of decentralization and make it more effective, in 1999 the state government passed the District Planning Committee Amendment Bill in the assembly. Under the new system, many powers of the state government, hitherto exercised from the state capital, were

decentralized and delegated to recently created district planning committees (DPCs) or *Zilla Sarkar*. The committees have a minister as chairperson, a district collector as secretary, and a number of official and non-official members. The DPC has powers and responsibilities to plan and implement many development programmes.

At the lower level, the village panchayats are expected to undertake and finalize proposals concerning various developmental activities. They then rank them by

priority and send them to the janpadh panchayat for approval. Subsequently, the DPC will deliberate, set financial priorities, and clear the projects in their annual plan. The village panchayats, however, have a greater role in the supervision and implementation of the projects.<sup>8</sup> Furthermore, the *Mahila and Bal Kalyan Samiti* (Women and Child Welfare Committee) has been formed to oversee women and child development and health programmes. This Committee is presided over by an elected woman representative, and the chief medical officer acts as its secretary. It meets once in a month and reviews activities concerning the welfare of women and children, public health as well as family welfare.

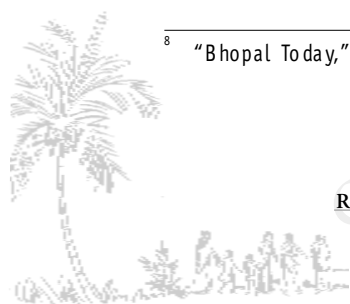
## Objectives of this Study

While the process of democratic decentralization was going on in the state, GOI decided to experiment with decentralized management of the family welfare programme. The plan was to implement the TFA on an experimental basis in one district of each state in the country in 1995-96. In 1996-97, GOI expanded the programme to all districts in all states of the country. In September 1997, GOI reviewed, redesigned, and renamed the TFA as the CNA approach. The way Madhya Pradesh went about implementing the TFA from 1995-97 and subsequently the CNA and the modifications it made in the process of implementation, have been reviewed and documented herein. It is especially interesting to study how effectively the state government implemented the TFA/CNA approach, given the degree of decentralization and the way they amalgamated the approach with the PRIs.

The main objectives of this study are the following:

- To describe the processes followed to implement the new system

<sup>8</sup> "Bhopal Today," MP Chronicle, March 25, 1999





- To record the opinions of personnel at various levels with regard to the new system and its implementation
- To analyze the implications of the new system on performance.

All personnel concerned with implementing the new system were interviewed. Hoshangabad district was selected to collect data at the district and subdistrict levels. As part of the methodology, one PHC or CHC and two sub-centres were selected. All relevant health personnel in the selected institutions were interviewed with the help of a broad set of guidelines prepared specifically for this purpose. All correspondence and other documents available at the department at all levels were collected and reviewed. Performance data were collected from the Directorate of Family Welfare and from the districts as well.

### **TFA in the Experimental Phase (1995-96)**

The state became aware of the TFA in the month of January 1995 on receipt of a letter from the Secretary of Family Welfare, GOI. In the absence of any guidelines, the state officers were not completely clear as to how the experiment with the new approach would proceed, but after discussions at the state level, they decided to select Narsinghpur as the experimental district. The criteria laid down for selecting the district were size, proximity to state headquarters, higher socioeconomic status, and consistently good performance in sterilization. In March 1995, the Director of Public Health and Family Welfare wrote to the Chief Medical and Health Officer (CMHO) of Narsinghpur about implementing the target-free approach and the decision of the state to experiment in that district. The letter further stated that under the new approach, the district would be exempted from targets for the year, but

targets should nonetheless be worked out using information collected in the ECRs. It also emphasized that need-based quality services should be provided. This was the only official reference to TFA that Narsinghpur received. The topic never figured in any discussions with the district either during monthly meetings or in the form of other correspondence.

As part of its routine activities, Narsinghpur carried out the eligible couple (EC) survey and updated the ECRs. After conducting this exercise, district and block officers and field workers were not clear about how to identify community needs. Hence, in his correspondence to medical officers, the district CMHO stated the following, “The targets for the family planning programme have been removed for the year. In the absence of sufficient guidelines, it is required that the workers estimate their own performance levels and perform better than what they have achieved in the previous year.” In order to comply, the statistical officer/assistants compiled information from the ECRs by institution and worked out the expected levels of achievement (ELAs) for each of the family planning methods without taking client needs into consideration. In fact, the ECR that was used was not designed to capture information on client needs. The assessment of the performance of field workers was based on what they had done the year before in that particular month. Thus, the TFA was similar to the target approach except for the fact that instead of the state fixing targets for the district, the district itself worked them out for the first time in the history of the programme. In reality, however, it can be inferred that the new approach was not operational because the district did exactly what it had done earlier.

In August 1995, the Secretary of Family Welfare (GOI) sent a letter to the State Secretary outlining the new approach. After reviewing the letter, state



officials sent a copy to Narsinghpur telling them to adopt relevant items that suited them. Instead of jointly discussing and formulating a strategy for implementation, the state directorate merely acted as a post office. As a result, the new approach was not properly implemented and there was confusion at both the state and district levels.

In 1995-96, overall family planning acceptance in the district dropped substantially, but MCH indicators such as ANC, natal and post-natal services improved over the previous year. In addition, the immunization coverage of infants showed remarkable progress.

### **Expansion of TFA (1996 onwards)**

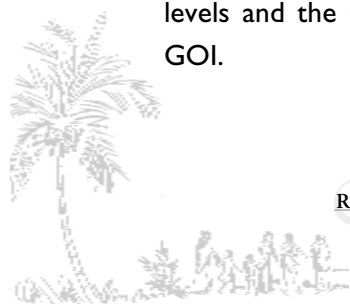
The decision to expand TFA to all districts of the country was made at a meeting of all State Secretaries in New Delhi on February 1 and 2, 1996. Actually, GOI had decided on expansion beforehand, and it called the meeting to ratify the decision it had already made. Though there was strong opposition from a few states, Madhya Pradesh agreed to abide by the GOI decision mainly because it had not truly implemented the new approach. In general, the state officials felt that TFA would be difficult for field workers to comprehend, but GOI promised that proper guidelines and a manual on implementation would be prepared and given to all states.

Subsequent to the meeting of State Secretaries, the Secretary of Family Welfare (GOI) wrote to them on February 14, 1996, about using the TFA in the family welfare programme. The letter stated the importance of the new approach, proposed training of health functionaries and other stakeholders, and suggested fine-tuning of IEC activities to suit the new approach. In the absence of data formats, the letter further outlined broad guidelines on the preparation of activity plans, on consolidating plans at various levels and the dates for submitting those plans to GOI.

The state directorate sent the Secretary's letter to all CMHOs and asked them to follow the instructions carefully. However, before the February 14, letter from GOI could reach the districts, another letter dated March 4, 1996, from the same Secretary addressed directly to the district magistrates arrived in their offices. That letter mentioned the training workshops and the budget for conducting them, including a set of guidelines. The letter created confusion because the districts were until then unaware of the developments that had taken place between GOI and the state, and at the same time the state was unaware of this letter on training as none of the districts, surprisingly, reported the matter.

On April 4, 1996, the Joint Secretary for Family Welfare (GOI) wrote a letter to the State Secretary about the training workshop with a copy of the Secretary's March 4-letter addressed directly to the districts attached. The budget for training was released according to a standard formula and had to be collected from the Regional Director's Office. The state later corresponded with the Regional Director and determined the exact amount allocated, but the amount was not enough to conduct workshops in all districts. Hence, the state decided to have three one-day workshops. Two were held in Bhopal: one for state officers, CMHOs and District Immunization Officers (DIOs) from a few districts, and the other for statistical officers and assistants. The third was held in Gwalior in November and December 1996, for the remaining CMHOs and DIOs and for media officers. Thus, training was confined to state- and district-level officers only.

GOI sent a detailed plan of the bottom-up approach to all states in the country on March 27, 1996. After reviewing it, state officials felt that the districts should follow the instructions in toto to estimate perceived needs and the corresponding service requirements.



The GOI schedule had 17 questions covering ANC, deliveries, post natal care, immunization of children, acute respiratory infections (ARI), diarrhoea cases among children and family planning. GOI coverage norms were also tagged to these indicators with the exception of family planning. In that regard, the states were advised to prescribe their own norms to arrive at total service requirements. The format provided an idea of the magnitude of the task of estimating demand for RCH and family planning services expressed as perceived needs instead of basing demand on the previous year's performance.

### **Implementation of TFA/CNA**

As a routine exercise, all districts are supposed to collect data on eligible women using the ECRs available at each sub-centre. Further, they are supposed to use the ECRs for working out MCH and family planning targets. However, with the top-down approach, the data collected annually from the ECRs was rarely used. With the introduction of the TFA, the state expected that ECR data could be effectively used; hence, the registers became the most important tool for formulating annual plans. The districts were asked to collect data from the ECRs and use the GOI prescribed coverage norms to arrive at ELAs for various MCH indicators. Calculating ELAs for MCH indicators was simplified by uniformly applying the state's birth rate despite the fact that all involved were fully aware of its enormous regional variations within the state.

As there were no norms specified by GOI for calculating family planning ELAs, the state decided on its own methodology. The state told districts to calculate ELAs based on perceived needs, not captured in the EC surveys. This led to confusion because these instructions could not be executed in a practical fashion. In the absence of a clear-cut methodology, the districts were later informally asked to consider past performance when formulating

activity plans. A few districts considered only the past one year's performance, while other districts used a three-year progressive average. (Hoshangabad used the three-year average.) Hence, there was no uniformity among the districts in the preparation of activity plans. Nonetheless, the new approach was implemented and the activity plans prepared by health workers were consolidated at the PHC, district and state levels. The state plan was prepared and sent to GOI by August 1996.

Preparing activity plans preceded training in the TFA manual because the manual had not yet been translated into the local language and because there was pressure from GOI to complete the state plan. Moreover, the state had yet to plan training activities. In September 1996, while the state was discussing its future course of action, GOI organized a two-day TFA orientation workshop in New Delhi for state-level officers to discuss the definitions and terms used in the manual. Both the Joint Director and the Deputy Director in Charge of Family Welfare from Madhya Pradesh, participated and on returning were assigned the task of conducting orientation training for all health personnel in the state.

Training was conducted for two days in February and March 1997, for state and district health and family welfare officers, senior programme officers and chief executive officers (CEOs) of the *Zilla Panchayats*. As Madhya Pradesh had implemented the *Panchayati Raj Act*, the CEOs' who had assumed the role hitherto played by the district magistrates and served as the chairpersons of the district health committees, were invited in order to familiarize them with the recent changes in the family welfare programme.

During training, the roles and responsibilities of the district health committees, the essence of the manual, and the monitoring and compilation of progress reports were discussed. Detailed plans for training



other staff were outlined, and district resource persons were identified. Thus, the implementation of TFA in the first year of the expansion phase was confined to state and district officers. This resulted in enormous confusion as each interpreted the new approach in his/her own way and calculated the expected levels of achievement for family planning according to convenience.

The actual training of district and other functionaries finally started in April 1997 with funds from UNICEF. It lasted over two months. All health personnel, members of PRIs, child development officers, representatives from non-governmental organizations, and AWWs were trained in these workshops. Meanwhile, the activity plans and progress reports that had been introduced along with the new approach were already in use, and during the year the sub-centres had collected information according to the prescribed formats. Later, information from the formats was compiled at various levels to form PHC, district and state plans, respectively.

Although training in the TFA should have preceded its implementation, efforts to incorporate TFA concepts were made by the health department. Nevertheless, confusion regarding the calculation of expected levels of family planning performance persisted as each district followed its own methodology. In the month of June 1997, the state reviewed the district plans and found many discrepancies. Immediately thereafter, the Director in his letter number 3, FW/TFA/97/5103-44, dated June 12, 1997, wrote the following to the CMHOs:

*“The district action plans from some districts were examined in the meeting of immunization officers on 29 and 30 May 1997. The district action plans prepared had a number of discrepancies, and these were discussed*

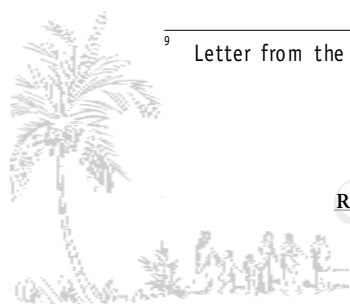
*with the Immunization Officers and clear directions were given to them to review the TFA manual and district action plan format and necessarily send it to the Directorate to the Joint Director, Family Welfare, after revising the district action plan accordingly, so that state action plan can be prepared on this basis and dispatched to Government of India.*

*You are, therefore, informed to please give personal attention to this matter and send the district action plan to the Directorate, on time, after thorough examination. I would like to mention here that an aspect is cross-checked at two-three places in the format of district action plan. So, prepared action plan fails if there are differences in data. Hence, full care, attention and cross-checking is required while preparing it. Normative need, felt need, service need and level of work done in district, were discussed in detail in the meeting of Immunization Officers and in this regard, the copy of directions sent by Government of India has already been sent to you. Do not make any changes in the format given by Government of India and give separate figures for each column. These facts are very much essential in preparing the district action plan.”<sup>9</sup>*

Following this letter, the districts reworked their action plans and submitted them to the state. Subsequently, the state action plan was prepared on this basis and sent to GOI in August 1997. Realizing the problems in calculating the ELAs for family planning methods, in 1998-99, Madhya Pradesh modified the ECR (see Annexure for details). The new ECR was well designed and covered various aspects of RCH and family planning. A brief description of it follows:

- Columns 1-17 provide information on background characteristics of the couples, number of children ever born and surviving,

<sup>9</sup> Letter from the Director, Family Welfare, to the district CMHO's, June 1997



number of births in the last year and current survival status

- Columns 18-21 are related to the woman's reproductive status and include questions on the menstrual cycle and a question on reproductive infections
- Columns 22-25 are questions on the unmet need for family planning
- Column 26 provides the pregnancy status of the women, while columns 40-45 are related to last pregnancy and place of delivery and assistance at delivery
- Columns 27-31 are on current use of family planning method, while questions 33-39 are on future intention to use family planning method
- Columns 46-51 are related to the immunization status of children.

Meanwhile, GOI had modified the TFA formats for making activity plans and progress reports and renamed the approach to the CNA approach. The number of formats was reduced and made simple to reduce the paper work. The new state ECR and the new CNA formats were introduced together at the field level after orienting health workers, and data collection commenced in the month of April 1998.

As funds for printing the new CNA activity plan formats were not available, the state had to resort to using handmade ones. Nevertheless, the state ensured that ECR data were collected and that activity plans were prepared. After collecting data, however, the ANMs did not know how to work out the unmet need for family planning services. Hence, the ECRs were sent to the statistical assistants in the PHCs'. The statistical assistants did not consider the ECR data

when working out ELAs and service requirements; instead, they resorted to the earlier methods of averaging performance over the last three years or considering the previous year's performance. Thus, the plan to use the revised ECR to work out ELAs for family planning based on client needs was derailed. The CMHO of Hoshangabad district reiterated this fact and mentioned the following:

*"Staff members were trained how to collect information from the newly designed ECR and during the course of training were introduced to the concepts of unmet need. However, the training did not specify any procedure of calculating unmet need from the data collected. The district-level trainers also were not sure about it and hence we checked with the state officials who were also not sure. Therefore, we had to resort to the old methodology."*

Interestingly, the ECRs that are supposed to be kept by the ANMs at the sub-centres are not available there; instead, they are at the PHCs in the custody of the block medical officer-in-charge. The data from them have rarely been used so their utility has been negligible. Unless proper procedures are laid down for using ECR data, the introduction of new registers or formats just tends to add paper work to the system. In the true sense, the ECR has not been properly used so the methodology for estimating ELAs did not include the client's perspective as proposed by the CNA approach. Since the state submitted the activity plans and the progress reports to GOI on time, GOI presumed that the new approach was working well and that health personnel had understood the concept and were implementing it in the right way.

With regard to the involvement of district planning committees, or *Zilla Sarkars*, in the implementation of the approach, very little has happened. Apart from orienting them and forming committees at various



levels, there has been little interaction between health providers and DPC members. The CNA approach was supposed to be worked out with the community and other stakeholders, but this has not happened. In fact, the new approach has not generated either community interest or participation, especially from the PRIs. The health coordination committee — that was constituted as part of the DPC — has yet to meet, so the health department continues to work in isolation.

Realizing the importance of an integrated approach and of the roles and responsibilities of the DPC, the state has decided to draw a blue print of activities and train DPC members. As a matter of fact, the male worker at the sub-centre has been transferred to the village panchayat and is supposed to report to the *Pradhan* (village headman) on a day-to-day basis. The state at present is drafting a plan of action for continuous involvement village panchayats in developmental activities, which would include health and family welfare.

## Family Planning Performance in Madhya Pradesh

### Limiting Methods

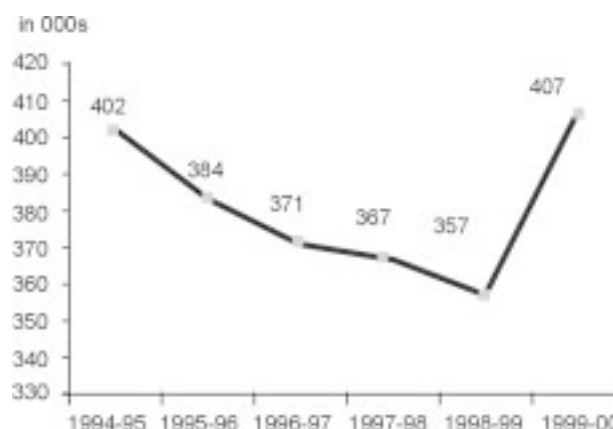
Table 1 depicts sterilization performance between 1994-95, the base year, and 1999-2000.

Table 1  
**Sterilization Achievements in Madhya Pradesh from 1994-95 to 1999-00**

Year	Sterilization Acceptance	Percent Increase/ Decrease*
1994-95	401,855	---
1995-96	384,342	-4.4
1996-97	371,731	-7.5
1997-98	367,092	-8.7
1998-99	357,243	-11.1
1999-2000**	407,000	+1.3

\* Base Year 1994-95; \*\* Provisional Figures

Fig. 1  
**Sterilization Performance in Madhya Pradesh**



Acceptance in 1994-95 was 401,855, but in the following year it declined by over four per cent. The downward trend continued with the introduction of the TFA to the extent of an 11 per cent drop in 1998-99 compared with the base year. However, in 1999-2000, there is an improvement in the performance level, and the state could record as many as 407,000 acceptors, which is higher than what it was before the introduction of TFA.

Figure 1 clearly demonstrates that sterilization acceptance in Madhya Pradesh steadily declined until 1998-99, when it was far below the 1994-95 level. If this trend were to continue, then with the growing number of eligible women, it would be difficult for the programme to sustain the efforts made to date. However, acceptance in 1999-2000 has increased by 14 per cent over the previous year. If this trend continues, then fertility in the state can be brought down to the levels envisaged in the state's population policy document.

### Spacing Methods

According to the 1997-99 National Family Health Survey, only one in every nine users was using a spacing method in Madhya Pradesh. Given that around one-fourth of its population lives in urban areas, the percentage of spacing method use in



relation to total use is quite small. The state is making considerable effort (through rigorous IEC campaigns and innovative programmes) to expand spacing services in urban areas, yet acceptance levels during the last five years as expressed in service statistics have declined substantially for all methods except oral contraceptives. The data are presented in Table 2, using 1994-95 as the base year.

### **IUDs**

In the five years since 1994-95, the number of IUD users has dropped by a third in Madhya Pradesh. The decline in 1995-96 was seven per cent; while the decline in IUD-use reached 30 per cent in the following year. In 1997-98, there was slight improvement over the previous year's performance, but in comparison to acceptance in the base year, it was down by 28 per cent. That decline increased further in subsequent years. Although state officials claim that there have been improvements in the quality of services, there is no evidence to substantiate this statement. Data on number of clients rejected/not found suitable for insertion, on continuation/dropout rates, on age and parity of acceptors and so on, have not been recorded properly. Furthermore, very few efforts have been made to improve the technical competency of health personnel.

### **Oral Pills**

Setting ELAs for oral pill use is done in terms of number of users, but acceptance records at district and lower levels provide information on the number of cycles distributed. This number is aggregated at the state level and divided by 13 cycles to get the number of users. Unlike sterilization and IUDs, pill acceptance registered an increase of over 20 per cent from 1994-95 to 1998-99. In 1995-96, the experimental phase of the TFA, pill use increased over the base year by seven per cent. In 1996-97, it increased an additional four per cent, though in absolute terms the performance that year was lower than that in 1995-96. Nonetheless, in the years following 1996-97 acceptance rose considerably.

### **Condoms**

The method of calculating the number of condom acceptors is similar to that used for determining oral pill users, and identical problems exist. The number of condoms distributed is divided by 72 to obtain the number of users. In 1994-95, there were 1,987,146 users; it increased by a negligible one per cent in the following year. After that the use of condoms declined drastically until in 1998-99 it was about 22 per cent lower than the base year. The decline continued into the following year as well.

Table 2  
**Annual Performance and Percentage Increase/Decrease of Use of Spacing Methods in Madhya Pradesh from 1994-95 to 1999-2000**

Year	IUD		Oral Pills		Condoms	
	AP	PI/PD	AP	PI/PD	AP	PI/PD
1994-95*	857,822	---	476,277	---	1,987,146	---
1995-96	797,548	-7.0	511,288	7.4	2,004,814	0.9
1996-97	598,012	-30.3	494,196	3.8	1,761,754	-11.3
1997-98	617,928	-28.0	560,167	17.6	1,650,486	-16.9
1998-99	576,188	-32.8	577,126	21.2	1,545,022	-22.2
1999-2000**	579,000	-32.5	630,000	32.3	1,458,000	-26.6

AP = Annual Performance; PI/PD = Percentage Increase/Percentage Decrease since 1994-95; \* Base Year; \*\* Provisional Figures



### Sterilization Equivalents

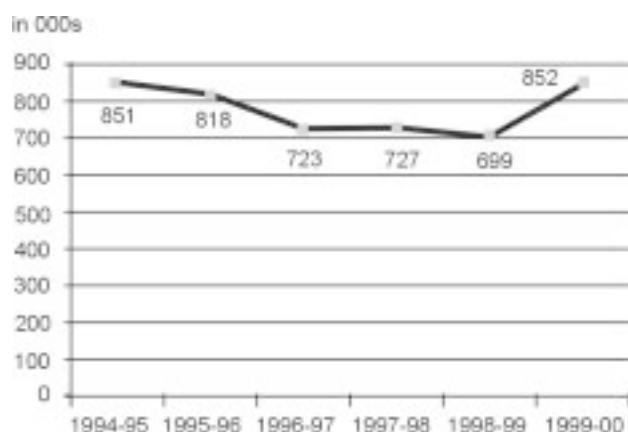
Besides providing family planning performance data, Madhya Pradesh also provides information on sterilization equivalents and uses it as a tool for monitoring family planning performance. Although the state has placed equal emphasis on both limiting and spacing methods, the pressure to achieve sterilization goals is immense. The methodology of using sterilization equivalents no doubt gives an overall index of family planning performance, but as the name suggests, it largely depends on sterilization performance and variations in it. In this methodology, all spacing method use is expressed as an equivalent of sterilization and is added to actual sterilization acceptance using a standard formula. The formula given by GOI is the following:

**Sterilization Equivalent = Sterilization + 1/3 the number of IUD insertions + 1/8 the number of condom users + 1/9 the number of oral pill users.**

An analysis of sterilization equivalents is presented in Figure 2.

The analysis reveals that overall performance in the state declined by 22 per cent from 1994-95 to 1998-99.

Fig. 2  
**Sterilization Equivalent Performance in Madhya Pradesh**



99. Acceptance was 851,000 in 1994-95 but dropped to 818,000 in 1995-96. With the expansion of the TFA to all districts in 1996-97, the decline was more rapid. It continued thereafter with slight variations until acceptance fell to 699,265 in 1998-99. However, in 1999-2000, overall performance improved and the state performed better than it had before the introduction of TFA in 1994-95. Though it is a positive sign, the quality of reporting continues to be the same. The number of regular users, the duration of use, and continuation rates for each spacing method are still not being collected and analyzed. To do this, either the monitoring formats have to be redesigned or inferences must be drawn from the existing data. Otherwise, no clear picture of the increase in contraceptive use and specifically in spacing method use will emerge.

On the whole, there was a drastic decline in family planning acceptance, barring oral pill use. State officials were concerned and attributed the decline to poor accessibility to clients and to lack of infrastructure in the state, but the major share of the blame must rest on the TFA/CNA approach and the confusion that resulted from its introduction. Yet, the recent increase in sterilization performance is an optimistic sign. In order to keepup the momentum, the state has formulated a state-specific population policy and has undertaken projects funded by international donor agencies to increase access to and improve the quality of RCH care services. A few of the projects initiated or in the process of initiation are described in the following section.

### Innovative Interventions

#### Madhya Pradesh Population Policy

Madhya Pradesh formulated a comprehensive state population policy that was approved by the State Cabinet in January 2000. One of the main objectives of the policy is to reduce the total fertility rate from the current level of 4.0 to 2.1 by 2011. For this,





Madhya Pradesh proposes to increase the contraceptive prevalence rate from the present level of 42.0 to 65 in 2011 through provision of universal access to a full range of safe and reliable family planning methods. This they plan to achieve by reducing the proportion of couples that have an unmet need for contraception to space and limit births by half by 2005, then by 75 per cent by 2009, and ultimately by 90 per cent by 2011. The second major objective is to reduce the IMR from 97 in 1997 to 65 by 2011. The main strategies to achieve these objectives are the following:

- Create a conducive environment for family planning and reproductive health services
- Increase demand for these services
- Collaborate with other development sectors, non-governmental organizations, and DPCs/PRIs
- Improve service delivery systems mainly to enhance access to and quality of services.

Madhya Pradesh proposes to review and develop appropriate implementation structures to achieve this goal. The health department is now preparing an elaborate decentralized implementation plan for each component of the policy with details of what should be done and the person responsible for it.

### **Integrated Population and Development (IPD), funded by UNFPA**

This project has just begun in the districts of Rewa, Satna, Sidhi, Chattarpur, and Panna. It addresses reproductive health and development issues including those of women. Improving technical competency of health staff and TBAs in safe delivery practices and neonatal care, vocational training for women, and gender sensitization of PRIs and their

participation in RCH programmes are additional features of the project.

### **Border Cluster District Project, funded by UNICEF**

The aim of this project is to reduce MIM rates by half in the next three years. A UNICEF study found that districts along the state borders have higher rates of fertility and mortality, especially MIM, and that these far-flung districts share social and cultural traits with districts across borders. Clusters of such districts were formed all over the country. Tikamgarh, Guna, Shivpuri, Morena, and Sheopur districts in Madhya Pradesh are part of the project. Project activities got underway early in 2000.

### **RCH Project funded by GOI and the World Bank**

This is a five-year project that started in 1997. The main objective is to improve the performance of the family welfare programme in reducing maternal, infant and child mortality, and unwanted fertility. The project has progressed in phases. The initial phase covered 11 districts; in the second year, another 14 districts were covered. In 1999, however, GOI directed that the project be expanded to all districts in the state. Activities include upgrading facilities, training, IEC, local capacity building, and management of the programme. To begin with, state functionaries were oriented and a six-day training course was held for field workers in the districts that were covered in the first two phases. Training is currently going on in the remaining districts.

In addition to this, the project proposes to include urban areas as the urban population — especially in the slums in major cities — is increasing rapidly where health infrastructure is very poor. In fact, providing basic health services to the growing urban slum population is a serious problem. To cater to this segment, the state has decided to work closely



with urban administrators and provide services through urban health posts and private sector providers. Necessary equipment and instruments will be provided to functioning centres as part of the project.

### **Sector Investment Programme by the European Commission**

The project aims to enhance the capabilities of personnel involved in the implementation of the CNA approach, using a sector-based approach to determine project priorities through a set of policy reviews of the following aspects of the programme:

- Workforce management options
- Delineation/decentralization
- Rational use of infrastructure
- Performance-based funding options.

Subsequent to these reviews, project activities will be decided at the field level. In Madhya Pradesh, the project began in October 1999 in the districts of Sidhi and Guna. It will be implemented over four years at an estimated cost of Rs. 100 crore. A state sector reform bureau has been constituted under the chairmanship of the Commissioner of Health to oversee project activities.

### **Vikalp Project of the Government of Madhya Pradesh, with the technical support of IIHMR, Jaipur**

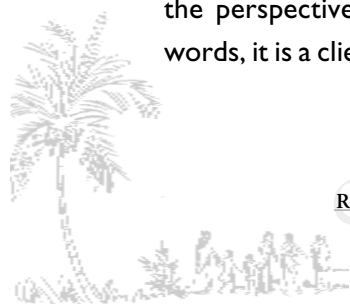
Vikalp is a system-based service delivery model that provides a comprehensive framework for implementing the family welfare programme from the perspective of the needs of clients. In other words, it is a client-centred, strategic approach based

on the simple tenet, "Help those who need services." It is carried out with the help of an appropriate service delivery system that aims to serve every couple interested in spacing or limiting childbearing and/or enhancing child survival. It also aims to prevent maternal mortality and morbidity including that from RTIs and sexually transmitted diseases (STD). The broad objective of the project is to develop a prototype for managing the family welfare programme at the district level, so that workers will be able to convert existing and future needs for family welfare services into acceptance. The prototype can then be used throughout the state to achieve the goal of population stabilization. The project will last for more than two years. It is currently in the experimental stage in Rajgarh district.

### **Janani Project, with the financial support of DKT International**

This is a social marketing venture that aims to provide good quality family planning products in a cost-effective way to the most vulnerable section of the society at an affordable price and at an easily accessible service delivery point. To accomplish this, the project has established Surya Clinics, where doctors, both graduates and postgraduates, are trained to provide clinical family planning and abortion services. Subsequent to their training, all doctors are entitled to use Surya Clinic franchises and provide sterilization, IUD and abortion services at pre-determined prices. In addition, the project uses the services of registered medical practitioners and chemists for referring clients to these clinics. To maintain the interest of the practitioners and chemists, incentives are paid for the clients referred. This project was initially started in Bhopal and the results were encouraging. Hence, the state decided to expand activities to other cities.

Apart from these innovative projects, the third phase of the DANIDA project has been sanctioned but is



yet to get underway. Likewise, JAIKA, a Japanese donor agency, is planning a feasibility study, so a situational analysis is underway in the districts of Sagar and Damoh. With all this help, it is expected that Madhya Pradesh will be able to reach its goal of achieving replacement fertility in the proposed time frame.

## Conclusion

Madhya Pradesh has made efforts to implement the TFA/CNA approach in light of the guidelines provided by GOI. Due to a delayed start, however, the approach could not be field-tested in the true sense for over a year after its introduction. When the health system was ready to absorb the new concept and implement it, GOI modified the existing data collection formats. State and district officers (medical and media) and CEOs of PRIs were oriented in their use, but field workers were not. Apart from attending the introductory training, there was no further involvement of the CEOs and very little has been done to involve them or their counterparts in block and village-level panchayat institutions. In addition, the central government's monitoring of the implementation of the new approach in both the original and revised forms consisted solely of logging in the monthly reports that the state regularly submitted. Due to this, GOI failed to understand what was really happening.

Although the state did not impose any targets on the districts, there was no clearly defined system for setting ELAs for family planning methods, so confusion about their calculation was widespread. There was a system for working out ELAs for RCH indicators, though calculating coverage norms based on a standardized birth rate lower than the actual one that further ignored regional and district variations defied the very principles of bottom-up planning. Moreover, although ELAs were set at the sub-centre and PHC levels, no effort was made to use ECR data.

In the period prior to and after the introduction of TFA/CNA, the overall number of family planning acceptors declined; the decline was more rapid after the state implemented the approach at the field level. Only in the past year has sterilization acceptance improved; it is higher than it was before the introduction of TFA/CNA. Barring oral pills, the extent of decline in spacing method use was considerable and has continued. Although the state is monitoring acceptance independently and in terms of sterilization equivalents, continuation rates for oral pills and condoms and retention rates for IUDs have to be analyzed.

Madhya Pradesh faces the arduous task of reducing fertility by 2011 as per the population policy approved by the state government. Low levels of social and economic development, alongwith early marriage for females and the low status of women are not conducive to the achievement of the objective. Problems are further compounded by the fact that the service delivery systems are inadequate and ill-equipped.

Though a lot of donor-funded activities have been initiated, the Family Welfare Department has not conducted a systematic review of the strategies. Instead of working out strategies through need-based projects, it has introduced several donor-funded projects whose objectives overlap. Further, it has not spelled out the strategy to address clients' needs, though unmet need has been repeatedly mentioned in the population policy document. Nonetheless, by addressing clients' needs, consolidating the gains of these innovative projects, and then expanding the successful ones, the state can achieve its population policy goals.

---

Madhya Pradesh faces the arduous task of reducing fertility by 2011 as per the population policy approved by the state government. Low levels of social and economic development, alongwith early marriage for females and the low status of women are not conducive to the achievement of the objective.

---



# Community Needs Assessment Approach for Family Welfare in Maharashtra



Sharad Narvekar  
A. D. Pendse  
K. M. Sathyanarayana



## Background

The implementation of the community needs assessment (CNA) approach in Maharashtra, from the inception of the programme in 1995 through 1997, has been reviewed and documented. The study describes the processes which were followed to implement the new system, recorded the opinions of various functionaries on the implementation process, and analysed the implications for family planning performance at the state and district levels. The findings were interesting and relevant; therefore, we have provided the following summary of the study as background information on the implementation of the CNA approach since 1997.

The Government of India (GOI) introduced the CNA approach on an experimental basis in 1995-96 and instructed Maharashtra to try it out. In the absence of any national guidelines, the state had been considering an alternative system of management to sustain the family planning efforts that it had made in the past. The Directorate of Family Welfare was concerned about the success of the family planning programme in reducing fertility because, although the contraceptive prevalence rate had increased considerably, fertility rates had remained more or less constant. In a review of the programme, it emerged that the emphasis placed on monitoring performance against targets without adequate attention to quality control had resulted in inflated achievement figures. Higher achievement figures led to a sense of complacency that allowed health planners to ignore field realities. As a result, area-specific planning and community needs and participation were overlooked. After the



importance of participatory planning was realized, it became the central theme of discussion.

Maharashtra decided to experiment with the CNA approach in two districts, namely Satara and Wardha. Satara, a progressive district, came out with a plan that emphasized the need for a maternal and child health (MCH) approach to family planning, whereas Wardha did not have any specific plan. The directorate encouraged Satara to try out its new plan while no changes were made in the implementation of the family planning programme in Wardha. The approach proposed by Satara was decentralized and better focused than the previous, target-driven

In 1996-97, the Government of Maharashtra (GOM) tried out the CNA approach statewide. The GOI manual on the CNA approach was reviewed by the state and modified to suit local requirements.

approach in terms of both quantitative and qualitative indicators, yet it did not ensure community participation. The levels worked out for various indicators were largely based on providers' perceptions even though the eligible couple-register was modified and a survey was conducted. The result was that MCH care

improved, but family planning acceptance declined. Nonetheless, the impact of family planning on fertility was significant because a higher percentage of younger women with lower parities were using contraceptive methods.

In 1996-97, the Government of Maharashtra (GOM) tried out the CNA approach statewide. The GOI manual on the CNA approach was reviewed by the state and modified to suit local requirements. The nomenclature was changed to "self-determination of targets." Sensitization training of all district

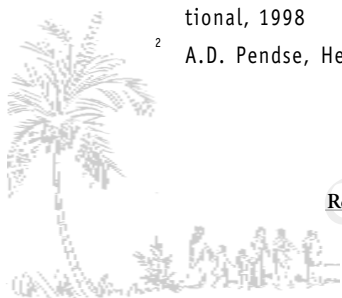
functionaries was carried out in April 1996. There was, however, no consistency among the district trainers due to the absence of specific guidelines, and so training was done in a haphazard manner. Furthermore, the procedure for calculating the expected level of achievement (ELA) for various indicators was discussed as part of training. The ELAs for family planning methods were based on certain proportions and districts were asked to determine ELAs accordingly. Thus, on the whole, the district action plans did not take community needs into consideration and so were not in tune with the principles of the CNA approach. This failure was attributed to confusion about the new system. Family planning performance declined considerably that year. In brief, the study concluded that though removal of targets was viewed as a way of definitely improving service delivery, several other related factors that could have facilitated improvements in quality of services were not addressed during the year.<sup>1</sup>

In addition to CNA implementation, as part of its Ninth Plan, the state identified areas for service concentration in order to achieve the national goal of "Health for All by the Year 2000 A.D."<sup>2</sup> Officials believed that addressing state issues along with the national agenda would improve lagging performance and provide better service quality. The state-specific areas were the following:

- Setting up the rural health institutions sanctioned by the master plan
- Expanding and strengthening national health programmes

<sup>1</sup> Subhash Salunke and Sharad Narvekar in Target for Family Planning in India, The Policy Project, The Futures Group International, 1998

<sup>2</sup> A.D. Pendse, Health Status of Maharashtra, Public Health Department, Government of Maharashtra, 1996



- Consolidating the infrastructure created by the first eight plans
- Upgrading and modernizing hospital facilities to improve curative services at district level
- Creating infrastructure in urban slums and low income areas
- Implementing the family welfare programme on the basis of CNA
- Implementing a mental health policy and providing mental health services at the grass-root level through the existing health infrastructure
- Training and reorienting medical and paramedical personnel
- Involving non-government organizations (NGOs) and private medical practitioners in the delivery of health services and in the implementation of national health programmes
- Providing adequate support to indigenous systems of medicine
- Controlling epidemics in tribal subplan areas, especially in sensitive Integrated Tribal Development Programme (ITDP) blocks
- Strengthening blood transfusion services through the state blood transfusion council
- Effectively implementing the AIDS control programme.

Even though the state's intentions were clear, it could not in the real sense integrate these areas into the national agenda as several issues requiring additional resources were yet to be discussed at the policy level. These included strengthening health infrastructure, improving IEC support, providing continuous training support, extending the CNA approach to urban areas, developing monitoring mechanisms based on client satisfaction and process indicators, and conducting concurrent evaluations.<sup>3</sup>

The present study is a continuation of the previous one, except for the fact that the implementation process has been reviewed since 1997. The aim is threefold: (i) To elicit the processes followed to implement the new system; (ii)

To record the opinions of personnel on the new system and its implementation; and (iii) To analyse the impact of the new system on performance. All personnel directly concerned with implementation at the Directorate of Family Welfare were interviewed.

Even though the state's intentions were clear, it could not in the real sense integrate these areas into the national agenda as several issues requiring additional resources were yet to be discussed at the policy level.

At the beginning of fiscal year 1997-98, state officials worked out a plan of action and budgetary requirements to accomplish each activity specified in the Ninth Plan. For a few ITDP activities, the state could generate its own resources and work out an integrated approach for implementation with other government departments. However, for activities such as improving/upgrading services in the secondary health system and effectively implementing the AIDS control programme, the state prepared proposals and negotiated financial assistance with international donor

<sup>3</sup> Subhash Salunke and Sharad Narvekar in Target for Family Planning in India, The Policy Project, The Futures Group International, 1998

<sup>4</sup> Review of State Project Documents (Unpublished)



agencies such as the World Bank, WHO, NACO, USAID, UNICEF, KFW, GTZ and UNFPA.

Some projects initiated since 1997 — that have directly or indirectly increased access to and improved the quality of health care — are summarised below.<sup>4</sup> They demonstrate that Maharashtra has made an all-out effort to address its health priorities.

- *Nava Sanjivini Yojana in ITDP funded by the GOM*  
The objective of this intensified project is to reduce the infant mortality rate (IMR) along with the incidence of measles, mumps, rubella and neonatal deaths in tribal areas. As the majority of the areas are inaccessible during the rainy season, special efforts are required to provide basic health and reproductive services. In this project, rescue camps, additional medicines, and staff and funds for mobility are provided. Vacant positions have been filled, and medical and paramedical personnel have been trained in neonatal management and provided with additional incentives. Efforts are also being made to ensure the services of specialists at each facility. Moreover, a link worker has been selected from the community itself and trained to provide services. A sum of Rs. 800 is given in kind to each antenatal care mother as a subsistence allowance. Various government departments such as tribal, social welfare, public works, revenue, and rural development are involved. Intensive monitoring of this project is being done at the state level and special monitoring of Grade IV staff is being carried out as well.
- *Basic Health Care Programme as part of the Indo-German Development Cooperation Project, funded by GTZ and KFW*  
This project is operating in the districts of Ratnagiri, Raigarh, Sindhudurg and Pune. It was

initiated at the end of 1996, came into being in 1997, and will in all probability, be completed by 2001-2002. There are two components: infrastructure and technical assistance. KFW is providing funds for construction, renovation and repair of buildings, vehicles, and equipment for the centres; GTZ is providing technical assistance to health personnel. The project is expected to improve the infrastructure and the competency of health personnel, thus satisfying the twin objectives of increasing access to the services offered as well as improving its quality.

- *Integrated Population and Development (IPD), funded by UNFPA*  
The project began in 1999 in the districts of Thane, Dhule, Gadchiroli and Chandrapur and in five to six corporations including Kalyan, Ulhasnagar, Bhiwandi, Thane, and Pune. It addresses reproductive health and development issues including those concerning women. Training traditional birth attendants (TBAs) in safe delivery practices and neonatal care, vocational training for women, and gender sensitization of *Panchayati Raj* institutions (PRIs) and their participation in reproductive and child health (RCH) programmes are additional features of the project.
- 4. *Reproductive Health Project, funded by UNFPA*  
Started in July 1997, in the district of Nasik and Wardha, the basic objective is to improve access to reproductive health services. The project will address clients' unmet needs and also provide funds for constructing labour rooms in sub-centres and repairing the sub-centres wherever required. Training medical officers and paramedical staff in the treatment of reproductive tract infections (RTIs) and sexually transmitted infections (STIs) is another objective of the project.



5. *Border Cluster District Project, funded by UNICEF*

The aim of this project is to reduce maternal and infant mortality (MIM) rates by half in the next three years. A UNICEF study found that districts along state borders have higher rates of fertility and mortality, especially maternal and infant mortality, and that these far-flung districts share social and cultural traits with districts across borders. Clusters of such districts were formed all over the country. Latur, Osmanabad and Nanded districts in Maharashtra are part of the project.

- *Urban RCH Programme, funded by GOI*

Nearly half of Maharashtra's population resides in urban areas where health infrastructure is very poor, so providing basic health services to the growing slum population is a serious problem. To cater to this segment of the population, as part of the RCH programme, the state has decided to create an urban infrastructure along the lines of the rural health posts. Necessary equipment and instruments will be provided as part of the project; in fact, Kits A and B have already been allotted to centres that are functioning.

- *Maharashtra Health Systems Development Project, funded by the World Bank*

The World Bank has allotted Rs. 725 crore to upgrade services in the secondary health system in districts, sub-districts, and community health centres (CHCs); improve management development; and strengthen institutions. The primary health system and the family welfare programme will also benefit from resulting improvements in service delivery at first-referral

units, from the establishment of hospital training teams, from tribal area strategies, from strengthening surveillance systems, and from improvements in referral systems.

- *Implementation of the AIDS Control Programme, funded by the World Bank and USAID*

Implementing the AIDS control programme has been a matter of concern as very few people in the state are aware of AIDS and its mode of transmission. At present, Maharashtra has the highest number of AIDS cases in the country; in fact, nearly two-thirds of the country's reported HIV cases are from Maharashtra alone.<sup>5</sup> The second phase of the programme has just begun. State and district AIDS societies have been formed as part of this phase to counter the rapid spread of the disease and to educate people. The state society has been made responsible for the overall management of the project, which will in turn be supported by district societies. The state and district societies will formulate district-specific plans that are effective and "people friendly." The state society will also coordinate with the Mumbai Municipal Corporation Society and the USAID-assisted Programme Management Unit to avoid duplication of activities. All stakeholders will be involved in planning, implementing and reviewing project activities. Furthermore, a draft policy on implementing the AIDS control programme has been prepared and is awaiting clearance from the government.<sup>6</sup>

## **Community Needs Assessment Approach**

Training workers in the CNA approach in 1997-98 was taken up as part of the state's RCH programme.

<sup>5</sup> Subhash Salunke in Programme for Children in Maharashtra, 1997

<sup>6</sup> AIDS Control Project-Phase II, Project Implementation Plan (Extract), Government of Maharashtra, 1999





Three workshops of two days duration, were organized for district and division-level officers to discuss the preparation of subcentre plans, based on the perceived needs of the community. Unfortunately the training was superficial, so the participants did not feel confident enough to undertake the exercise in their districts. Realizing the importance of CNA, the state experimented with participatory planning on a pilot basis in Nasik district. A capacity-building workshop was organized jointly with UNICEF in March 1997, and all state and district-level officers attended. In addition, a manual prepared by GOI and UNICEF titled Training of ANMs for Building Effective Community Partnerships for Implementing the Reproductive and Child Health (RCH) Programme, was given to the state.

The importance given to CNA is highlighted in this letter from the Joint Secretary, GOI, dated May 14, 1997, to the Secretary (Family Welfare).

*“As you are aware, the health programmes for mothers and children have been going from strength to strength. In the last ten years, you have all made tremendous efforts in making the immunization programme a big success. Based on the achievements of the UIP, we were able to expand the programme into larger Child Survival and Safe Motherhood (CSSM) issues. The CSSM programme has equipped all sub-centres with equipment and drug kits and has strengthened PHCs and first referral centres in many areas.*

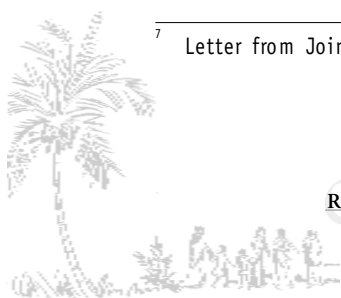
*Programmes also have life cycles and as they grow, they expand and change. Two such major changes have come about in 1997. One is the whole process of people’s participation and community needs assessment. This will be the overriding approach and underlying principle of all health activities henceforth. The other is the*

*expansion of the CSSM programme into the RCH programme to include all issues of women’s health, and adolescent health. The nationwide effort of people’s participation in planning and supporting the implementation of the health programmes requires a lot of change in attitude and methods of working of all the stakeholders — government health workers, community, elected leaders, NGOs, the private sector and other government departments. One of the ways of bringing about changes in attitudes and methods of working is through training. Training in RCH will be integrated and will take place in many rounds, so that there is an opportunity for the health staff to practice what they learn and to share their successes and failures with their colleagues in the subsequent training sessions. The beginning of this training is the six days ANM training to be implemented all over the country. What is unique about this is a fresh approach to training — both in the methodology as well as in the training of trainers themselves. For the first time, we have been able to develop a facilitator’s guide for the trainers. A vast number of trainers will be trained all over the country with the aid of facilitators’ guide and training will be monitored and evaluated. We welcome your full participation in using this guide, adapting it to local examples and situations and in giving feedback to us.”<sup>7</sup>*

The facilitator’s guide was reviewed and certain modifications were made by the state to adapt it to their requirements. It was then translated into the local language in record time, and copies were made available at the time of training. As stated in the GOI letter, the workshop was for six days duration. The overall objectives of the training programme were as follows:

- Increase the participants’ ability to train groups, especially the TBA, using participatory methods

<sup>7</sup> Letter from Joint Secretary, Family Welfare] GOI, addressed to State Secretary on May 14, 1997



- Increase the participants' ability to enhance community participation in planning and implementing health programmes
- Enhance the participants' understanding of the way the RCH programme will improve maternal/child health.

The translated guide contained specific topics to be covered in each session and pedagogic tools to be used to ensure that uniform training was imparted throughout the state. A brief description of the topics covered in the training programme is given below:

- Adult learning principles
- Methodology of assessing community needs and preparing sub-centre action plans
- Methods of participatory learning for action (PLA)
  - *Chapati* diagram
  - Seasonal diagram
  - Relative ranking
  - Participatory mapping
  - Village transect — fish bowl technique
- Training needs assessment
- Participatory planning for key RCH activities
- Role play as a means of communication
- Organising training sessions for AWWs and TBAs
- Field visit for practicing the above-mentioned skills.

In addition to the central government's RCH training package, the state government introduced four data collection formats to be used by sub-centre functionaries to assess community knowledge and to estimate the ELAs for RCH and family planning indicators. They were designed to help the sub-centre functionaries and their supervisors determine the service requirements, the perceived needs and the awareness levels of their communities. Format 1 assesses programme requirements, Format 2 surveys community needs and knowledge about services, Format 3 is used to calculate community needs in a sub-centre area and Format 4 is used to work out service needs. Taken together, the formats were expected to furnish both community and provider perspectives, thus satisfying the basic premise of the CNA approach while simultaneously helping to implement the programme by addressing specific micro-level strategies.

Format 1 developed by GOM resembles Form 2 of the GOI TFA Manual of 1996. This format provides the state coverage norms for various RCH indicators in percentages presented in absolute numbers alongside the percentage norms of each indicator. Assuming a birth rate of 25 per 1,000 population and population coverage of 5,000 by each sub-centre, the annual programme requirement of each sub-centre is worked out. No norms have been specified for family planning methods, but it is mentioned that the ELAs have to be calculated for each of the family planning methods by using eligible couple (EC) surveys.

While Format 1 provides the programme requirements, community needs and knowledge about RCH services among women who have a child between 0-5 years is captured in Format 2. In all, there are 15 questions, each related to an indicator. All the questions are asked to women who have not undergone sterilization while questions 10-15 are applicable only to those who are already sterilized.



Format 1:

**Norms Prescribed to Calculate Programme Requirements in 1997-98**

S. No.	Types of Services	Percentage Coverage Norm of GOM	Programme Requirement for a Subcentre with 5000 Population and Birth Rate of 25
1	Antenatal registration	100%	125 plus 10% wastage 138
2	Early antenatal registration	60%	84
3	Awareness about signs/symptoms of high-risk pregnancy	100%	138
4	Detection of anaemic antenatal (AN) mothers and treatment with Iron and Folic Acid (IFA) tablets	50%	69
5	Tetanus toxoid (TT) for AN mothers	100%	138
6	Three visits completed to AN mothers	100%	138
7	Institutional deliveries	33%	46
8	Skilled attention at delivery	95% (of total deliveries)	131
9	Recording of birth weight	95% (of expected births)	119
10	Awareness about signs/symptoms of high-risk newborn	100%	125
11	Infant immunization	100%	125
12	Children given Vitamin A doses	100%	125
13	Oral Rehydration Salts (ORS) treatment for diarrhoea among 0-5 years children (assuming a prevalence of two episodes/year)	100% of under-5 years children with diarrhoea	1,250 ORS packets
14	Treatment of pneumonia (assuming a prevalence of two episodes/year)	10% of children with cough and fever	125
15	Sterilization Spacing methods	As per client needs <b>the ELA has to be calculated</b>	<b>Through EC Survey</b>

Format 2

**Community Needs/Knowledge about Services, 1997-98**

S. No.	Indicator	Mothers (all mothers having a child in 0-5 years age group)												
		1	2	3	4	5	6	7	8	9	10	Replying Yes	Total Mothers	% Replying Yes
1	What will you do when you have missed three periods? (Antenatal registration)													
2	If answer to question 1 is yes, then at what month should this registration be done? (Before 16 weeks)													
3	What are the danger signs of high-risk pregnancy? (Bleeding, fits, edema over legs)													



S. No.	Indicator	Mothers (all mothers having a child in 0-5 years age group)										Replying Yes	Total Mothers Yes	% Replying
		1	2	3	4	5	6	7	8	9	10			
4	Is there a need to take tablets for improving haemoglobin during pregnancy? (IFA tablets)													
5	Is there a need for injections during pregnancy? (Tetanus toxoid)													
6	How many antenatal checkups should a pregnant woman have? (Minimum three)													
7	Where do you want to have your delivery? (Home/hospital)													
8	Who should conduct your delivery? (Trained/untrained person)													
9	Is it necessary to record the weight of the newborn? (Yes)													
10	For which illnesses should a newborn be taken to the doctor? (Low birth weight, difficult respiration, congenital defects)													
11	Which vaccines should be given to your child before the first birthday? (DPT/Polio/BCG and measles — one of these three or all)													
12	What medicine needs to be given to a child for prevention of night blindness? (Vitamin A)													
13	Would you give less/more fluids to your child if it has diarrhoea? (More fluids)													
14	If your child is coughing and sneezing (rapid breathing and difficulty in breathing) would you take the child to the doctor? (Yes)													
15	Do you wish to have more children? (Yes/No/Question does not arise)													
a.	If yes; do you wish to delay the next child? (Yes/No)													
b.	If yes; which spacing method would you like to use?													

Questions 1 to 15 — For all mothers who have a child in 0-5 years age group and who have not accepted sterilization

Questions 10 to 15 — For all mothers who have a child in 0-5 years age group but have accepted sterilization

Expected answers are given in the brackets. Match the responses of the mothers with the expected answers and then enter Yes/No in the small squares against each mother



### Format 3

#### Calculating Community Needs in a Sub-centre Area, 1997-98

S. No.	Types of Services	Percentage of Mothers Needing Services (from Format 2)	Actual Service Need
1	Antenatal registration	% arrived from Format 2	Estimated programme need in Format 1 * % in column
2	Early antenatal registration	— do —	
3	Awareness about signs/symptoms of high-risk pregnancy	— do —	
4	Detection of AN mothers with anaemia and treatment with IFA tablets	— do —	
5	TT for AN mothers	— do —	
6	Three visits completed to AN mothers	— do —	
7	Institutional deliveries	— do —	
8	Skilled attention at delivery	— do —	
9	Recording of birth weight	— do —	
10	Awareness about signs/symptoms of high-risk newborn	— do —	
11	Infant immunization	— do —	
12	Children given Vitamin A doses	— do —	
13	ORS treatment for diarrhoea among 0-5 years children (assuming a prevalence of two episodes/year)	— do —	
14	Treatment of pneumonia (assuming a prevalence of two episodes/year)	— do —	
15	Sterilization Spacing methods	Mother willing to accept sterilization and mother willing to accept spacing methods	Actual numbers

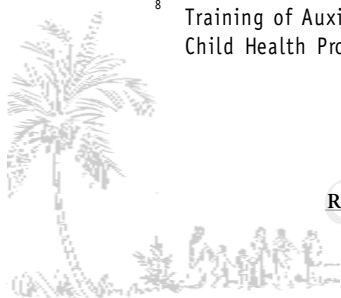
In Format 3, the community needs are calculated based on the correct responses given by women in Format 2. Thus, the percentage of women who responded appropriately to each question in Format 2 is multiplied by the absolute number of the corresponding indicator in Format 1 to get the community needs of each indicator.

In Format 4, the service need is calculated after considering the programme requirement from Format 1 and the community needs and knowledge from Format 3 alongwith the past year's performance. The expected numbers obtained in

these two formats are compared with the past year's performance and then the ELAs for RCH and family planning activities are worked out. Consequently, the numbers arrived at become the annual work plan of the sub-centre. These sub-centre plans are aggregated to arrive at PHC plans, then district and state plans are compiled in a similar manner.<sup>8</sup>

The GOI reviewed Maharashtra's guide and felt that the formats were not in tune with what had been proposed in the CNA manual. The state officials explained that they were gathering additional information that would be useful in formulating

<sup>8</sup> Training of Auxiliary Nurse Midwives for Building Effective Community Partnerships for Implementing the Reproductive and Child Health Programme, GOI, GOM and UNICEF, 1997



Format 4

**Calculating Service Needs in a Sub-centre Area, 1997-98**

S. No.	Indicators	Programme Need (from Format 1)	Community Need (from Format 3)	Previous Performance from Registers	Expected Number for Providing Services
1	Antenatal registration				
2	Early antenatal registration				
3	Awareness about signs/symptoms of high-risk pregnancy				
4	Detection of anaemic AN mothers and treatment with IFA tablets				
5	TT for AN mothers				
6	Three visits completed to AN mothers				
7	Institutional deliveries				
8	Skilled attention at delivery				
9	Recording of birth weight				
10	Awareness about signs/symptoms of high-risk newborn				
11	Infant immunization				
12	Children given Vitamin A doses				
13	ORS treatment for diarrhoea among 0-5 years children (assuming a prevalence of two episodes/year)				
14	Treatment of pneumonia (assuming a prevalence of two episodes/year)				
15	Sterilization Spacing methods				

district-specific plans, including IEC plans, based on the knowledge and perceptions of the community. After deliberations with state officials, GOI agreed to the use of the formats but insisted that monthly reports be submitted along the national guidelines.

Regional officials were trained from June 16-21, 1997, at the Health and Family Welfare Training Centre in Kolhapur. District-level officials were trained by August 30, 1997. Although the state was then prepared to train peripheral functionaries, it came to their notice that GOI had committed to the training of auxiliary nurse midwives (ANMs) only. At this juncture, state officials felt it was

imperative to train peripheral functionaries, as it would provide administrative convenience for the management of the programme. Hence, they decided to approach UNICEF for funds to train male health assistants, health workers, and at least one medical officer from each Primary Health Centre (PHC). Once the proposal was agreed upon, financial and other training-related logistics such as training load, venues and dates of training were worked out. The training of peripheral staff started at the district level in October 1997 and was completed by March 1998. In all, 4,468 medical officers, 4,206 male and 3,369 female health assistants, and 9,410 male and 11,866 female health workers were trained.



In November 1997, the state directorate decided to review the way RCH training was being conducted in 15 districts. The study looked into different aspects of the training programme including the involvement of district administrators, coordination with training institutions, training arrangements, standardization in use of training materials and pedagogic tools, participant feedback and monitoring. The study identified certain strengths and weaknesses and recommended mid-course corrections that were to be incorporated later.

It was found that the training was well accepted by staff members. As it was done jointly for medical and paramedical personnel, it resulted in better coordination at the field level and involved medical officers more in implementation. However, at the same time, it was found that the facilitators were not very comfortable with PLA techniques, so the sessions were less interactive. Hence, reorientation of the facilitators for two days in PLA was suggested. It was also noted that a lack of proper coordination between district administrators and training institutions had somewhat hampered the training programme and that the monitoring of participants after training had not been done as expected. The review, therefore, called for more involvement of the district administrators especially in extending organizational support. Other recommendations included assistance in carrying out CNA at the sub-centre level and participation of male workers in developing and implementing sub-centre work plans.<sup>9</sup>

### **Experience in Implementing the CNA Approach**

Since the RCH training started in the middle of fiscal year 1997-98, it could not be put into practice at the community level at that time. The state had already

worked out district ELAs for the year as stipulated by GOI and had submitted them to the central government as its annual plan. While the state plan was ready, the districts had yet to submit theirs, so they followed exactly what was in the state plan and made no effort to assess community needs that year. At this point, the state did not insist that the districts at least experiment with what they had learned during training. Table I below summarizes the ELAs for RCH and family planning indicators for 1997-98.

The implementation of the CNA approach in 1998-99 was initiated at the beginning of the fiscal year. As suggested by the RCH training review, the master trainers were reoriented for two days in PLA techniques. Since training was completed, the districts were asked to assess community needs in accordance with the formats developed. A few districts carried out the survey, but the majority could not do so. After compiling programme and community needs alongwith the previous year's performance, the districts could not easily work out the ELAs. They, therefore, added a percentage to the previous year's performance and submitted it as their work plans. Since there was no consistency in the way the districts had calculated their ELAs, the state directorate again worked out district-level ELAs, thus ignoring the principles of bottom-up planning.

Even though a lot of effort went into developing the training package and into the actual training, the effort was not particularly relevant because of problems with the formats. The expected numbers in Format 3 are appropriate responses of only women who have a child between 0-5 years of age. Calculating the community needs on this basis and then arriving at the ELAs will result in a gross underestimate because this format considers only the appropriate responses. Further, it is applicable to

<sup>9</sup> Sharad Narvekar, Mid-term Review of RCH Training Programme in Maharashtra, 1998

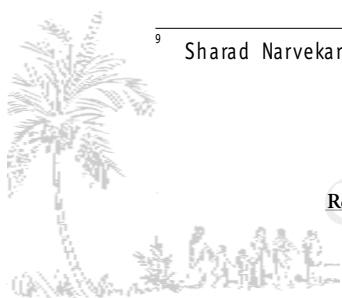


Table 1  
District/Corporation ELAs for the Year 1997-98

District/Corporation	0-1 Children	ANC Mothers	Sterilization	IUD	Oral Pill Users
Raigarh	48,108	52,531	11,740	8,663	10,880
Ratnagiri	38,824	42,394	10,203	9,244	8,092
Thane	88,409	96,537	17,772	13,778	15,495
Ahmadnagar	89,675	97,920	25,669	24,029	18,663
Dhule	67,098	73,267	16,656	11,346	12,430
Jhalgaon	83,767	91,469	23,204	19,316	15,901
Nasik	82,712	90,316	22,248	17,007	17,184
Pune	92,418	100,915	26,373	16,533	16,169
Solapur	70,474	76,954	20,843	16,626	14,812
Satara	64,144	70,042	18,394	13,515	14,569
Kolhapur	68,153	74,419	21,274	17,838	15,788
Sangli	57,184	63,310	18,931	15,064	14,141
Sindhudurg	21,000	23,040	4,409	5,525	5,078
Aurangabad	44,099	48,153	11,672	8,896	11,966
Beed	49,163	53,683	14,318	12,075	10,445
Jalana	37,347	40,781	10,429	8,920	8,311
Nanded	69,208	75,751	19,515	8,740	14,702
Latur	45,365	49,536	13,996	10,675	10,024
Osmanabad	33,760	36,864	10,257	8,299	6,728
Parbhani	57,181	62,438	15,408	13,807	14,104
Akola	58,025	63,360	16,041	14,485	14,768
Amarawati	44,099	48,153	11,492	10,786	9,773
Buldhana	50,218	54,835	11,256	12,047	11,636
Yeotmal	54,016	58,982	15,305	14,697	13,898
Bhandara	53,805	58,752	16,271	13,657	12,863
Chandrapur	47,264	51,160	12,699	11,305	12,149
Gadchiroli	21,100	23,040	6,012	4,681	5,686
Nagpur	43,677	47,392	12,768	11,970	11,496
Wardha	27,430	29,952	8,563	7,506	6,361
<b>District Total</b>	<b>1,607,723</b>	<b>1,755,946</b>	<b>443,718</b>	<b>361,030</b>	<b>354,112</b>
<b>Corporations</b>					
Gr. Bombay	258,264	282,013	45,053	49,491	11,625
New Bombay	7,807	8,525	1,918	1,566	1,709
Thane	26,164	28,570	4,716	6,010	4,879
Kalyan	30,384	33,178	4,719	4,990	4,971
Nasik	21,100	23,040	6,503	4,106	3,281
Pune	42,200	46,080	14,315	9,461	6,081
PCMC	16,669	18,200	4,412	2,428	2,040
Solapur	15,614	17,050	7,471	3,878	3,588
Kolhapur	10,550	11,520	3,767	3,175	3,372
Aurangabad	17,724	19,354	5,432	5,169	4,364
Amarawati	12,871	14,054	3,080	3,163	2,936
Nagpur	42,200	46,080	10,736	10,351	6,795
<b>Total Corp.</b>	<b>501,547</b>	<b>547,664</b>	<b>112,122</b>	<b>103,788</b>	<b>55,641</b>
<b>State Total</b>	<b>2,109,270</b>	<b>2,303,610</b>	<b>555,840</b>	<b>464,818</b>	<b>409,753</b>





only a segment of women; women of zero parity or newlyweds who are likely to space or give birth soon are not captured. To compensate, past performance was taken into consideration. If one were to follow this methodology, however, the entire exercise of looking into various aspects in different formats seems to be futile as the services provided are definitely not addressing community needs. Apart from getting an idea of future intentions to use family planning methods and of the specific IEC messages that would need to be designed to increase community awareness, nothing concrete emerged from the formats. State officials want to modify them, but to date very little effort has been made to do so.

In 1999-2000, there has not been any significant change in the state's approach to the implementation of CNA. However, the recent Multiple Indicator Cluster Surveys (MICS) for both rural and urban areas and the RCH survey findings for 15 districts have made the extent of inter-district variations in RCH and family planning indicators very apparent. As a matter of fact, the survey results have been thoroughly discussed at the state level in a series of meetings between state and district officers. Nonetheless, with an aim of addressing state-specific priorities and plans, the Secretary of Health of Maharashtra intends to formulate an RCH policy. In this context, letters have been sent to all districts requesting that they prepare district-specific plans in accordance with the present scenario and with

the goal of "Health for All by the Year 2000 A.D." In a two-day workshop titled "Formulation of RCH Policy for Maharashtra" jointly organized by GOM and the POLICY Project at Pune from August 20-21, 1999, district-level officers made a presentation on district plans. At the end of the workshop, the state decided to take into consideration the issues that had emerged and has constituted a committee to draft a state-level RCH policy.

## Family Planning Performance in Maharashtra

### Limiting Methods

As shown in Table 2, the state target for sterilization for the year 1994-95 was 600,000 of which 582,454 were actually performed. In 1995-96, the year when the CNA approach was introduced in two districts, performance declined in absolute terms but showed a percentage increase because the ELA (expected performance) was lower than the previous year. With the introduction of the new system statewide in 1996-97, performance dropped substantially. This pattern was observed elsewhere in the country. During that year, however, in the absence of any targets, the state had worked out the ELAs using the proportion 7 per 1,000 population, which considerably increased the expected level; in fact, it was the highest in five years. In 1997-98, performance levels were close to those of 1994-95, but in 1998-99 performance once again dropped.

Table 2  
**Expected and Actual Levels of Sterilization Performance in Maharashtra from 1994-95 to 1998-99**

Year	Expected Performance	Actual Performance	Per cent Achieved
1994-95	600,000	582,454	97.1
1995-96	572,100	566,168	99.0
1996-97	615,650	518,897	84.3
1997-98	555,840	571,476	102.9
1998-99	560,000	532,714	95.1

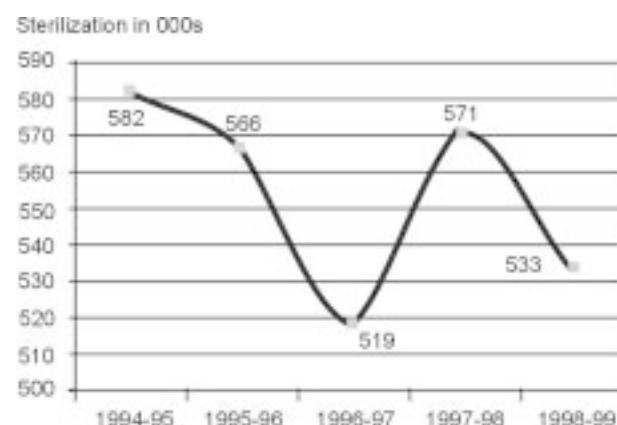


Figure 1 shows that since the advent of the CNA approach, sterilization acceptance in Maharashtra has been fluctuating and has yet to reach the level prior to CNA introduction. Nevertheless, the state is closely and regularly monitoring the age and parity of sterilization and IUD acceptors, and it was mentioned during our discussion that there have been slight changes. The age at acceptance of sterilization was 29.0 years in 1994-95 but decreased to 28.4 years in 1998-99, and the average parity dropped from 2.90 to 2.85 children. State officials are confident that if the performance level in the coming two years is increased to around seven lakhs (700,000) and if age and parity are closely monitored, the state will be able to achieve its goal of reaching replacement fertility.

Table 3 displays the distribution of sterilizations in each quarter over the period 1994-98. Performance uniformly increased from the first to the last quarter in those years. In the year 1994-95, 15 per cent of total performance was achieved in the first quarter; this increased to 21 per cent in the second quarter, 29 per cent in the third quarter, and 35 per cent in the fourth quarter. A similar pattern of performance is observable for subsequent years even after the introduction of the CNA approach in 1996-97.

It can be inferred that although enormous changes were made in the planning process to implement the new approach, actual performance seems to be

Fig. 1  
**Sterilization Performance in Maharashtra**



more or less similar to what it was before its introduction as nearly three-fifths of operations were done in the latter half of the year.

### Spacing Methods

According to the 1992 National Family Health Survey, only one in every eight users was using a spacing method in Maharashtra.<sup>10</sup> Given that half of its population is in urban areas, the percentage of spacing method use in relation to total use is quite small. The state is making considerable efforts through rigorous IEC campaigns to expand spacing services in urban areas, yet acceptance levels as expressed in service statistics have declined substantially during the last five years. The data are presented in Table 4 using 1994-95 as the base year.

Table 3  
**Per cent Distribution of Sterilization by Quarter in Maharashtra from 1994-95 to 1997-98**

Quarters	1994-95	1995-96	1996-97	1997-98
1 <sup>st</sup> Quarter	15.2	16.1	15.7	15.3
2 <sup>nd</sup> Quarter	20.9	21.4	20.6	23.0
3 <sup>rd</sup> Quarter	29.3	28.8	27.0	27.9
4 <sup>th</sup> Quarter	34.6	33.7	36.7	33.8

<sup>10</sup> National Family Health Survey, Population Research Centre and International Institute for Population Sciences, Maharashtra, Mumbai, 1995



Table 4

**Annual Performance and Percentage Increase/Decrease of Use of Spacing Methods in Maharashtra from 1994-95 to 1998-99**

Year	IUD		Oral Pills		Condoms	
	AP	PI/PD	AP	PI/PD	AP	PI/PD
1994-95	476,283	***	418,194	***	1,168,747	***
1995-96	470,630	-1.2	483,269	15.6	1,163,775	-0.4
1996-97	453,321	-4.8	375,537	-10.2	685,855	-41.3
1997-98	418,711	-12.1	375,187	-10.2	594,164	-49.2
1998-99	402,450	-15.5	358,821	-14.2	586,489	-49.8

AP = Annual Performance; PI/PD = Percentage Increase/Percentage Decrease since 1994-95

**IUD**

Since 1994-95, the number of IUD users has steadily decreased. In 1995-96 it dropped by one per cent; in 1996-97, it dropped by five per cent; and in 1997-98 and 1998-99, it was down 12 and 16 per cent, respectively. This considerable decline coincides with the introduction and adoption of the CNA approach. However, in spite of the drop in acceptance rates, there have been changes in the age and parity of acceptors. The age at acceptance dropped from 25.4 years to 24.6 years by 1998-99 and average parity decreased from 1.6 to 1.5. Districts are collecting data on retention rates, but the data has not been analysed at the state level.

**Oral Pills**

The common practice for setting ELAs for oral pill use is in terms of the number of users, but performance records at district and lower levels provide information on the number of cycles distributed. That number is aggregated at the state level and divided by 13 cycles to get the number of users. In other words, the calculations are restricted to numerical achievements without considering vital information regarding continuing users and dropout rates. As was observed with IUDs, following the introduction of the CNA approach in 1996-97, acceptance steadily declined. The extent of decline in 1998-99 was 14 per cent since 1994-95.

**Condoms**

The calculation of condom-users is based on the same methodology used for determining oral pill-users, and identical problems exist. The number of condoms distributed is divided by 72 to obtain the number of users. In 1994-95, there were 1,168,747 users, and in the following year it remained more or less at the same level. After that, however, use dropped by as much as 50 per cent. In other words, condom use in 1998-99 was half of what it was in 1994-95.

This analysis of spacing methods clearly reveals a drastic decline in performance over the reference period. State officials explained that they aren't too concerned about oral pill and condom use because they feel that the data on these methods are unreliable. Hence, the focus is more on clinical methods of family planning, but even those acceptance rates have declined. The officials put the blame on the CNA approach and the confusion that resulted from its introduction. Nonetheless, they are optimistic now that the systems are in place, that functionaries have been trained, and everybody knows what is expected. They concluded by saying that if everything works well, performance will definitely improve in the next couple of years.



## Reproductive and Child Health Indicators

While family planning indicators have been disappointing, RCH indicators have not. With the inclusion of the CNA approach in the RCH programme, considerable efforts have been made to improve access and quality. The department is monitoring all the RCH indicators specified in Format 4 on a monthly basis. Significantly, both the MICS and RCH surveys have indicated remarkable improvements. For instance, the RCH survey indicates that nearly nine out of 10 pregnant women were registered for antenatal care (ANC) and more than half of them received ANC services (three visits). Moreover, the percentage of institutional births and births attended by trained personnel increased, and over three-fourths of infants were fully immunized.<sup>11</sup> As a result, maternal and infant mortality has declined. The sample registration survey data in 1997 pointed out that the infant mortality rate was 46 in contrast to the national average of 71.<sup>12</sup> This clearly implies that by concentrating on RCH indicators, Maharashtra has been able to nearly achieve the goal of “Health for All by the Year 2000 A.D.”

## Conclusion

Maharashtra has taken enthusiastic steps to address state health priorities and goals. By integrating various projects funded by international donors, it has increased access to and improved the quality of services. Further, it successfully amalgamated state-level issues with the national agenda and introduced the CNA approach in 1997-98 as part of the RCH programme.

In addition to the central government’s RCH training package, the state government designed data collection formats to address programme

requirements, to survey community needs and knowledge about services, to calculate community needs in a sub-centre area, and to calculate service needs. However, apart from getting an idea about future intentions of using family planning methods and of the specific IEC messages needed to increase community awareness, nothing concrete emerged from the new formats. Though state officials feel the need to modify them, very little effort has been made to do so.

Due to flaws in the design of the formats and to the increase in paper work, it was difficult for the staff, specifically sub-centre staff, to comprehend and implement the CNA approach. RCH training started in the middle of fiscal year 1997-98, so it could not be put into practice at the community level that year. In 1998-99, the districts could not work out their ELAs with precision. As there was no consistency in the way the districts calculated their levels, the state directorate once again worked out district-level ELAs ignoring the principles of bottom-up planning.

During this period, family planning indicators dropped substantially including a considerable decline in the use of spacing methods. The state is monitoring the age and parity of IUD and sterilization acceptors though, and both have dropped somewhat. Unless minor changes are made in the design of implementation, it will be difficult for the state to adopt the bottom-up approach and step up its performance levels.

RCH indicators on the other hand, have shown decided improvement. With the inclusion of the CNA approach in the RCH programme, Maharashtra has been able to nearly achieve the goal of “Health for All by the Year 2000 A.D.”

<sup>11</sup> National Family Health Survey, Population Research Centre and International Institute for Population Sciences, Maharashtra, Mumbai, 1995

<sup>12</sup> Sample Registration System, Registrar General of India, 1998



# Community Needs Assessment Approach for Family Welfare in Orissa



K. M. Sathyanarayana  
Ranjana Kar



## Background

Orissa is the ninth largest state in India covering over 5 per cent of the total land area of the country. According to the 1991 census, the population was 31.66 million; 972 females were enumerated for every 1,000 males. Nearly nine out of 10 persons resided in rural areas, the lowest level of urbanization in the country though the urban population increased from 11.8 per cent in 1981 to 13.4 per cent in 1991.

In general, low population density coupled with enormous regional variations characterizes the settlement pattern in the state. The population density in 1991 was 203 persons per square kilometre varying from less than 100 persons per square kilometre in tribal districts to more than 500 persons per square kilometre in coastal districts. The average size of a village is around 500 persons, but villages of less than 500 account for nearly two-thirds of the total number. Accessibility to these villages is a major problem as 30 per cent of the area in coastal and hilly tracts has yet to be connected by all-weather roads.<sup>1</sup>

The literacy rate is 48 per cent, which is slightly lower than the national rate of 52 per cent. However, there are wide variations among different areas, caste groups, and sexes. The literacy rate in rural areas is 46 per cent while in urban areas it is as high as 72 per cent. Likewise, among males the literacy rate is 63 per cent whereas it is only 35 per cent for females.

<sup>1</sup> Ranjana Kar in Spatial Information of Demography and Health, 1996 and Health Statistics of Orissa, 1997, Government of Orissa



Regarding population growth and fertility, Orissa recorded an average annual growth rate of 1.95 per cent during 1981-91 compared with the national growth rate of 2.1 per cent; it was the fourth lowest growth rate in the country. The birth rate declined from 34.6 in 1971 to 26.8 in 1996, and the death rate declined during the corresponding period from 15.5 to 10.7. The total fertility rate was 4.7 in 1971, but it declined to 2.9 in 1993—15 per cent lower than the national rate. The age-specific fertility rates in the past two decades have shown significant changes with peak fertility occurring in the age group 20-24 years.

While fertility levels in the state are lower than those nationwide, the death rate is significantly higher. In fact, in 1998,

Orissa registered the highest infant mortality rate (IMR) in India: 98 compared with 72 per thousand live births for the country as a whole.

While fertility levels in the state are lower than those nationwide, the death rate is significantly higher. In fact, in 1998, Orissa registered the highest infant mortality rate (IMR) in India: 98 compared with 72 per thousand live births for the country as a whole. The IMR itself accounts for nearly one-third of the total annual deaths. About three-fifths of infants die in the neonatal period, and slightly less than one-third die

within a day of birth. It is worth noting that the state recorded the lowest number of institutional deliveries and deliveries by trained personnel in India.

According to estimates, the percentage of couples effectively protected from pregnancy increased steadily from 15 per cent in 1971 to 40 per cent in 1992. In 1980, the rate in Orissa was 27 per cent, which was higher than the national rate of 22 per cent. By 1992, however, it was lower than the national rate, indicating a slow down in family planning acceptance. Furthermore, there were differentials

between urban and rural areas in terms of modern contraceptive use. The contraceptive prevalence rate in urban areas was 45 per cent as opposed to 32 per cent in rural areas. This was mainly due to greater use of all modern methods of contraception by urban women. However, many users in both areas were users of a limiting method while use of spacing methods, though higher in urban areas, was not significantly different from that in rural areas. Almost all current users, irrespective of their place of residence, received family planning services from a public health facility. On the whole, it can be inferred from these statistics that there was nearly total dependence on public health facilities for services and that the use of spacing methods was limited.<sup>2</sup>

A large proportion of the available time of all health personnel at all levels in Orissa is devoted to preventive and curative health care. Because of the high incidence of epidemics, the state has established Zilla Swasth Samiti (district health committee) in all districts with District Magistrates as the chairpersons. The District Magistrates review all the health and family welfare programmes each month and submit a report to the State Secretary. As the defacto chiefs of all programmes in the districts, the collectors also monitor family welfare programmes and thus play an important role in the management of health and family welfare in the state. Other government departments such as social welfare, revenue, and education also participate in the health and family welfare programmes.

## Objectives of the Study

This study was undertaken to document the experience and understanding of the implementation of the Target Free Approach (TFA). The GOI in September 1997, reviewed, redesigned and renamed

<sup>2</sup> National Family Health Survey: Orissa, Population Research Centre, and International Institute for Population Sciences, Mumbai, 1992 and Sample Registration System, Registrar General of India, 1998



the TFA as the Community Needs Assessment (CNA) Nonetheless the specific objectives of this study are as follows:

- To record exactly the processes followed to implement the new system
- To solicit the experiences of personnel with the new system and its implementation
- To analyze the implications of the new system on performance.

All personnel responsible for implementing the new approach in the state were interviewed.

The former 13 districts in the state were reorganized into 30 districts in 1993. Khurda and Ganjam districts were selected to collect data at the district and sub-district levels. (Khurda was chosen by the state as the trial district for initial implementation of the TFA approach). As part of the methodology, two Primary Health Centres (PHCs)/Community Health Centres (CHCs) and four sub-centres were selected and visited. All relevant health personnel in the selected institutions were interviewed using broad guidelines prepared specifically for this purpose. Correspondence and documents available from the department were collected and reviewed. Performance data were collected from the Directorate for Family Welfare and from the districts as well.

## Introduction of the TFA Approach and Experiences

The implementation of the new system in the experimental and subsequent phases must be understood in the context of the following specific issues facing the state at that time, issues that might not have been taken into account when the decision to adopt the TFA approach was made at the national level.

- The burden of managing health programmes after the formation of 17 new districts in 1993 increased considerably. Furthermore, the health budget as a percentage of the total state budget has been decreasing drastically. Since the population is virtually totally dependent on public health institutions, it is imperative that services of proper quality are provided. To this day, however, the systems to provide such services are yet to be in place, and sufficient allocations to the newly formed districts are yet to begin. Even though efforts are continuing, it will take sometime to establish systems in general and support systems in particular and run the programmes in accordance with GOI norms.

- Due to its geographical location, Orissa is one of the few states in the country where almost all the natural disasters (droughts, floods, cyclones) occur. Floods and cyclones most frequently ravage the densely populated coastal areas, and droughts are common in southern and western Orissa. Nearly one-third of the total area of the state suffers one of these recurrent natural calamities from time to time. Most disasters are followed by epidemics and related health hazards, so indicators in health and nutrition have almost always been adverse in the state, especially for women. Health workers have to spend a major part of their time combating disease outbreaks.

Most disasters are followed by epidemics and related health hazards, so indicators in health and nutrition have almost always been adverse in the state, especially for women. Health workers have to spend a major part of their time combating disease outbreaks.

- Orissa has higher morbidity rates than any other state in the country. Furthermore, if health indicators such as number of institutions and their maintenance, doctor/population ratio, nurse/population ratio, population/bed ratio, number



of vehicles in running condition, and availability and supply of medicines are analyzed, taking into account location and accessibility to villages, then the overall status is dismally poor.

- The Department of International Development (DFID) has been operating in the state since 1981 so has had a great deal of experience with the development of the health sector. The evaluation they conducted after the completion of phase two of their project indicated major shortfalls in the health system. Despite the provision of training and infrastructure, the quality of services was poor, and many users were dissatisfied. Some of the buildings constructed as part of the project had already fallen down due to lack of maintenance. Outreach services had suffered due to lack of transport, and drugs had always or often been in short supply. System failure was widely seen to be the underlying cause. The Government of Orissa (GOO), recognizing the need for reform, has already begun to work to introduce changes in personnel policies and in systems for procuring drugs. Phase three of the DFID project is expected to contribute to this agenda.<sup>3</sup>
- In addition to the target-fee approach, the GOI began a Reproductive and Child Health (RCH) programme. It is underway but is still in the infancy stage. Efforts have been made to gear up organizational resources, but it will take sometime before the RCH programme is implemented.

In this context, the state was working out specific strategies using available resources and was at the same time negotiating projects with donor agencies such as the World Bank, UNFPA and DANIDA.

The state selected priority areas and is in the process of setting up a coordinating cell for all donor projects. On the question of readiness to implement TFA, the state Director of Family Welfare mentioned the following:

*“Improving the government systems, increasing access to services and improving quality of services are the major concerns of the government. With frequent natural calamities, most of our time is spent on preventive and curative activities. Virtually with little presence of private sector medical institutions in rural areas, the responsibility of providing services is totally on the public sector. The public sector especially in the newly formed districts does not have proper infrastructure, supportive and peripheral staff in position. Vehicles according to norms have not been allotted and the existing ones that are in condemnable position have not been replaced. Mobility to interior and inaccessible areas is a problem especially during calamities. The majority of sub-centres is in a dilapidated condition and moreover is located outside the villages making it unsafe for the workers to reside. Communicable diseases are rampant and medicines are in short supply. Every natural calamity is followed by an epidemic so most of us are busy managing the aftermath of the recurring calamities.”*

After becoming aware of the TFA in February 1995, the state started gearing up to implement it. At this juncture, officials were engrossed in addressing state priorities while at the same time preparing to experiment with the new approach. In March 1995, the state chose the newly formed Khurda to be the experimental district for implementation. The stated rationale for selecting the district was its proximity to state headquarters; nevertheless, the most important consideration was that the district was represented by the then Chief Minister of the state.

<sup>3</sup> Orissa Health and Family Welfare Project—Phase 3, Department of Health and Family Welfare, Government of Orissa, December 1997





In April 1995, the Directorate issued a letter to the Chief District Medical Officer (CDMO) that stated the following:

*“In the financial year 1995-96, GOI is thinking of implementing the target-free approach in one district of the state on an experimental basis and therefore we have decided to make your district target-free. Emphasis will be on providing quality services and hence you will have to ensure it. Further you are requested to carry out the eligible couple survey, and sensitization about the new approach for district-level functionaries will be taken up first at the Directorate on receiving further instructions from the GOI.”*<sup>4</sup>

When Khurda was selected, there were no proper health systems in place. As it was part of state headquarters, the office of the CDMO was in Bhubaneswar itself. It was moved to the district in 1998 but, for all practical purposes, the CDMO maintains two offices: one in Bhubaneswar and the other in Khurda. The staff is in both places: the logistics unit is still located in Bhubaneswar while the other units in the department have shifted to Khurda.

Until May 1995, there was no communication whatsoever from the Directorate of Family Welfare regarding guidelines for implementation. However, on June 8, 1995, the Director, in letter number 14124 to the CDMO, informed him of the introduction of the TFA in the district. The monthly formats proposed by GOI for monitoring the new approach were enclosed. The letter mentioned the following:

*“It has been proposed by the GOI to adopt one district in the state where quantitative targets are to be replaced by qualitative indicators as a pilot approach in 1995-96. The state government has decided to select Khurda district for the purpose. Accordingly, no specific targets in family planning methods are being given to the district. The GOI has prescribed performa for monitoring family welfare indicators in respect of the district selected for the purpose. A copy of the same is enclosed for submission of the detail of FP acceptors according to age, parity, etc. This monthly report should be furnished to this Directorate by the 5<sup>th</sup> of the succeeding month to which the report relates. All the prescribed monthly reports for family planning and CSSM programmes should be continued in addition to the GOI monitoring report. Further, the monitoring of the institution wise report for the district should also be furnished without targets and achievements to the state. In addition, the GOI guidelines say that 10 per cent of sterilization cases covered should be vasectomy cases. The monthly reports starting from May 1995 may be furnished accordingly and all institutions intimated about the detail procedure for effective adoption of the pilot project.”*<sup>5</sup>

Following this letter, district-level officers attended a two-day workshop conducted by the Joint Director of Family Welfare, wherein a plan for intensive and specific monitoring at various levels was drafted. Sub-centre formats for weekly and monthly reviews at sector and block levels were finalized along the lines of the GOI format and a means of assessing the programme in the field with due emphasis on age and parity of acceptors was drafted.

Khurda, as part of its routine activities, had by then carried out the Eligible Couple (EC) survey and had

<sup>4</sup> Letter from Directorate to the CDMO of District Khurda informing him of the selection of the district for experimentation in TFA, April 1995

<sup>5</sup> Letter from Directorate to the CDMO of District Khurda specifying the GOI guidelines and the monthly formats for reporting family planning and CSSM programme performance, May 1995



updated the eligible couple registers (ECRs). An interesting point is that in 1993-94, Orissa had introduced five-year, sub-centre-level, printed ECRs. These records were well maintained. Since the survey had already been completed by May 1995, the district statistical officer had been able to collate the information on age and parity of eligible women by institution in very little time.

During monthly meetings at the district and block levels, block-level and other functionaries were informed of the new approach, and the newly developed monitoring formats were introduced in

the subsequent month.

In the absence of targets, the district worked at a leisurely pace with less pressure from senior officials. Yet, the monitoring of performance in family welfare was done routinely in weekly sector-level meetings and in monthly meetings at the block, district, and state levels.

Following this, the district did not have any specific methodology to work out the expected levels of achievement (ELAs) for each of the family planning methods. Hence, the district decided to do exactly what it had done before the introduction of the new approach. The statistical officer stated the following:

*“The GOO, much before the introduction of the new approach, had developed indirect estimates based on the population of each sub-centre. The assumption was based on 5,000 population; and the target for each year and for each method used to be: 30 new acceptors of sterilizations; 30 new acceptors of IUDs; 15 new acceptors of oral pills; and 65 new acceptors of condoms. Using this very logic, the expected levels of achievement of each method for the year were arrived at.”*

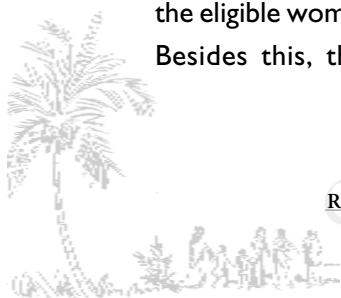
Thus, the ELAs in the experimental year in the experimental district were determined on the basis of population. Information on both age and parity of the eligible women that was available was not utilized. Besides this, the methodology did not take into

consideration the perspective of the potential users because the ECR—that was in use—was not designed to collect information on unmet need. Hence, the estimation of ELAs in the experimental phase remained more or less similar to the previous approach except for the fact that instead of the state fixing the targets for the district, the district worked out its own.

In the last week of August 1995, the Directorate sent a letter addressed to the State Family Welfare Secretary of (GOI) to the district along-with one of their communications. The letter detailed the MCH approach to family planning in Tamil Nadu. Since MCH indicators had not been up to expectations in Orissa, the state Directorate was keen to understand what Tamil Nadu had done. After review and discussion at the state level, however, nothing new emerged except for an emphasis on a birth-based approach and on quality of services.

In the absence of targets, the district worked at a leisurely pace with less pressure from senior officials. Yet, the monitoring of performance in family welfare was done routinely in weekly sector-level meetings and in monthly meetings at the block, district, and state levels. Monitoring of each sub-centre worker, continued to be based on what the worker had achieved in the same period in the previous year. Apart from the introduction of new monitoring formats from GOI, no other significant change occurred. On the whole, in fact, experimenting with the new approach was limited to using the newly designed monitoring formats. In the absence of proper guidelines, the district did what it could do best, and district officials in the first year of experimentation showed a sort of commitment to achieve what they themselves had proposed.

With the exception of oral pills, the acceptance of family planning in 1995-96 in Khurda district declined



compared to the previous year (1994-95). MCH indicators during this period improved slightly as there was a higher percentage of ANC registration and follow-up, more births were assisted by trained personnel, and there was better coverage of children under immunization programmes.

### **Expansion of TFA**

In a meeting of State Secretaries in New Delhi on February 1 and 2, 1996, GOI announced plans to extend TFA to all districts in the country. This decision was not taken in a systematic way because a review of the implementation in various states was not conducted nor was the process for identifying clients considered. Many states that had made unsuccessful attempts to implement TFA were opposed to the plan but were left with no option as GOI had already made a decision. GOI continually insisted that the new approach would improve the quality of services, and in this context it was agreed that GOI would prepare and circulate a set of guidelines and a manual to all the states. The manual was expected to provide clarity in implementing the new approach. The majority of the participants felt dissatisfied at the way the decision had been made by GOI; Orissa was no exception.

After the meeting, the Directorate in Orissa elaborated on the procedures to implement the GOI directive and issued letters to all the CDMOs on March 22, 1996, along-with the national Secretary's letter. The letter, marked URGENT/IMPORTANT, asked them to follow the instructions carefully.

In this context, the Director of Family Welfare mentioned the following:

*"Regarding the TFA approach, neither fertility nor family planning is a major problem because the state surprisingly is doing well in the family planning programme and the fertility levels are coming down significantly in the tribal*

*districts when compared with those of the coastal ones. What is required from the national government is a feasibility analysis of whether the new approach, given the situation in Orissa, can be implemented or not. This was not taken into consideration despite our repeated requests. In other words, the state was not fully prepared to test or implement the new approach but the national government order had to be executed and, therefore, according to instructions we have communicated with the districts and implemented the programme."*

Before the February 14, 1996 letter from GOI could reach the districts, the District Magistrates received a letter directly from the Secretary of Family Welfare (GOI), dated March 4, 1996. It mentioned a set of guidelines, the workshops and the budget for conducting them. The allocation of budgets to the districts did not take into consideration the actual number of PHCs but rather assumed an average number of them. The funds had to be procured from the regional director's office. A few districts received more funds than they required, but most districts did not. The state was unaware of this letter, and none of the districts, surprisingly, brought it to the notice of the state. Nevertheless on April 4, 1996, the Joint Secretary, Family Welfare, GOI wrote a letter to the State Secretary about the workshop with a copy of the GOI Secretary's letter addressed directly to the districts. The state issued this letter to the districts as a matter of routine on April 20, 1996. Later, after corresponding with the regional directors, the exact funding for each district was worked out, and the workshops at the state, district, and block levels were conducted between July and August 1996.

This apart, GOI addressed a letter to the State Secretary on March 27, 1996, that provided a detailed plan of the bottom-up approach. The letter was dispatched to the districts on April 4, 1996. The state felt that the districts should follow the



GOI instructions exactly to estimate perceived need and service requirements. The procedures for working out both were outlined in detail. Further, the GOI schedule had 17 questions covering ANC, deliveries, post-natal care, immunization of children, Acute Respiratory Infections (ARI), diarrhoea cases among children, and family planning. GOI coverage norms were also tagged on to these indicators as examples, except for family planning. With regard to family planning, the states were advised to prescribe their own norms to arrive at total service requirements.

State-level officials sent the letter to the districts and started monitoring their progress. When they discovered that family planning service requirements were grossly underestimated, they decided to develop state estimates. Hence, as a follow-up to the GOI letters dated February 14 and March 27, the state Directorate issued a reminder in letter number 11873/FW-DE-1/96 on May 10, 1996, to all the CDMOs. It outlined a specific methodology for estimating family planning service requirements and state norms for the indicators that differed from GOI norms. The letter stated the following:

*“Please refer to the guidelines issued vide this Directorate circular No. 4854/FW dated February 27, 1996 and DO No. 10844/FW dated April 25, 1996, for preparation of PHC-level and district-level plans under the target-free approach. The due date for receipt of district-consolidated reports is May 15, 1996. In this regard, it is expected that the block-level plans have already been given a final shape taking into account the population size, demographic indicators, and family planning status of the eligible couples. During field checks, it was observed that the guidelines and the examples given for assessing the service needs of a sub-centre have not been properly understood, and action plans drawn up include underestimating the service needs on several counts. In most cases, the family planning service needs have not*

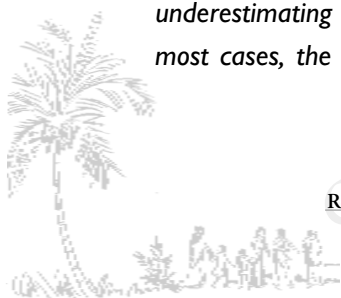
*been properly assessed. The analyses of the eligible couples in regard to their family planning service status and service needs have not been properly done.*

*In order to further simplify in understanding the issues, the following examples may be brought to the notice of all peripheral staff.*

- A. MCH service assessments are to be made on the basis of the birth rate of 28 per 1,000 population, and an average population of 5,000 per sub-centre should be assumed. Accordingly, the estimates of services shall be as follows:
- B. Primarily, the eligible couples register should be updated through complete enumeration of the entire population. The number of couples by parity, that is, the number of children and number of couples practising each of the family planning methods by parity, should be found out for assessing the service needs.

The estimated number of eligible couples per 1,000 population is 165. Hence, the estimated number of couples for a sub-centre with 5,000 population shall be 825. The percentage of eligible couples protected in the state is around 40 per cent. These indicators may be used to check the eligible couple survey findings with 10 per cent plus or minus range. As per the state average performance, the minimum number of acceptors per subcentre of 5,000 population in each of the four methods is as follows:

FP Method (1996-97)	Estimated Number of Acceptors for One Sub-centre Area
Sterilization	30
IUD	30
Oral pill (13 cycles per user)	15
Condom regular users (72 pieces per user)	65



	Service	Estimated Number
I.	Antenatal registration 100%	140
	- Pregnancy wastage 10%	14
	- Total ANC	154
II.	Early antenatal registration 60%	92
III.	Detection and referral of high-risk pregnancy 15%	23
IV.	Iron/Folic acid to ANC 100%	154
V.	Treatment of anaemic expectant mothers 50%	77
VI.	TT (Mother) 100%	154
VII.	Institutional deliveries 25%	35
VIII.	Delivery by trained attendant 95%	133
IX.	Growth monitoring of live birth 95%	133
X.	Referral of high-risk births 10%	14
XI.	Infant immunization 100% of live births	140

The actual service need may be more, but the above state-level estimation may be used as a practical guide to check the block-level plans, and any abnormal deviation beyond 10 per cent needs to be explained with reference to the actual number of couples in need of different methods.

*It is, therefore, requested that the plans already drawn up may be rechecked on the basis of the above norm. The district consolidated report should be submitted by May 15, 1996, along with detailed notes on the indicators and estimation adopted for the purpose.”<sup>6</sup>*

Using the state-specific guidelines, the districts recalculated their estimates and compiled the reports in accordance with GOI activity plans. These plans were then submitted to the state by June 1996.

While the state prepared the activity plans, training in the GOI manual was postponed. State-level trainers had to be identified, and the manual had to be translated into the local language. While the translation of the manual was going on, GOI conducted training for state-level officers in New Delhi in September, 1996. Two senior officers—

the Director of the State Institute of Health and Family Welfare (SIHFW) and the Joint Director (Family Welfare)—attended. On their return, the translated manual was finalized, and copies were made. On November 6 and 7, 1996, training for state and district officials was conducted. No formal training was organized for other district officials and functionaries except for orientation during monthly/weekly meetings.

Khurda, which already gained had the experience of implementing the new approach in the previous year, continued with what they had done earlier. Thirty-three introductory workshops were held by August 1996. Later, the district started providing services according to the activity plan formulated along the lines of the state circular.

District performance in family planning in the year 1996-97, was affected by the TFA. Compared with 1994-95, the year before the target-free approach was introduced in Khurda, the overall decline in family planning performance was four per cent, and the extent of decline in condom use was to the extent of 10 per cent.

<sup>6</sup> Letter from Directorate to the CDMOs of all districts specifying the state guidelines for implementing TFA, May 1996.



Ganjam district, unlike Khurda, did not have prior experience in implementing the new approach. It followed all the instructions set by the state Directorate and then devised a plan. As one of the more progressive districts in the state, it did not take much time to adapt to the new approach. As many as 44 one-day workshops, were conducted at various levels in the district in the absence of any guidelines. In April 1996, the district carried out the ECR survey and then estimated family planning service requirements and formulated its activity plans by the end of May. With regard to overall family planning performance, there was a negligible decline. For instance, in 1995-96 in Ganjam there were 13,823 sterilizations; after the introduction of the new approach in 1996-97, 13,457 sterilizations were performed. However, a decline in the acceptance of spacing methods was observed, and the extent of drop in condom acceptance was considerable.

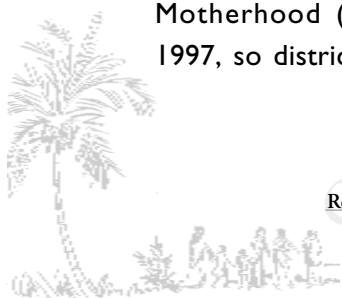
In 1997-98, preparations for instituting TFA started in the beginning of the fiscal year. UNICEF gave funds for orientation training, and the state and the districts worked out a training itinerary. In Ganjam, seven to eight two-day workshops were held for medical officers and IEC staff from June 6-28, 1997, at district headquarters. Three facilitators from the state and an equal number from the district conducted the training. Similarly, a five-day training programme was organized at the block level, and 44 such programmes were held before August 1997. Over 2,900 persons from the health department and from outside (other departments, NGOs, panchayat and ward members, school teachers, and so on) were trained at a cost of nearly Rs. 9 lakh (a *lakh* = 100,000).

In Khurda, on the other hand, health functionaries were busy with the Child Survival and Safe Motherhood (CSSM) training until November 1997, so district staff gave very little attention to

TFA. In spite of repeated reminders from the state, the district did not respond, so at the end of the fiscal year TFA training funds were withdrawn. Hence, none of the block-level staff or the peripheral staff was officially trained in the approach. Khurda did exactly what it had done in the past two years. The ECR survey was conducted and then activity plans were prepared following the state guidelines given the previous year. However, in May 1997, the district received a letter from the Additional Secretary (Family Welfare) in Orissa, that suggested remedial steps to enhance the decreasing acceptance of IUDs. The letter clearly stated that the expected level for IUDs would have to be tripled and submitted as the ELA in the district activity plan. Khurda did as instructed.

Ganjam district also received the letter about increasing IUD acceptance. In addition to this letter, around the same time, another letter from the Directorate proposing a new methodology for working out the ELAs was issued to all the districts. (Surprisingly, district officials in Khurda did not get that letter and were unaware of it.) Instead of using the earlier estimates, this letter instructed the district to follow a new approach to arrive at ELAs for each family planning method and to estimate family planning service needs (see Box 1).

The district statistical officer based his calculations for 1997-98 on the guidelines described in Box 1. For family planning methods, the basis for the coverage norms shifted from the general population to couples, and parity was included. This methodology seems to be more realistic than the previous one. How the state arrived at these coverage norms is still a mystery. Nonetheless, this methodology was communicated to all the PHCs in Ganjam though the medical officers and the health workers in the selected PHCs have yet to use it to estimate family planning service needs.



Overall, family planning acceptance in 1997-98 in Khurda district dropped substantially from 1994-95 levels. Major declines were observed for sterilization and condoms while it improved for IUDs and oral pills. A similar situation existed in Ganjam district as well. In both districts, IUD acceptance improved considerably because of the letter from the state requiring higher ELAs.

Our impressions of state-specific problems gained from earlier discussions with the Director (Family Welfare) were reaffirmed during our discussions with the CDMOs. The CDMO in Ganjam, one of the better districts in the state, declared the following:

*“Our district is doing reasonably well in family planning although the performance in the last two years has come down. The district is more economically advanced than the rest of the state. However, the health department and facilities need considerable improvement. In many places, the infrastructure at block, sector and sub-centre levels is in a dilapidated state as the maintenance budget is very meagre and does not allow for major repairs. Even after repeatedly sending reminders to the state, nothing has been done. Auxiliary nurse midwives (ANMs) quarters are not available in half of the sub-centres and wherever available, they are in a bad shape. Hence, the ANM cannot reside there. If she stays in the village headquarter, she is not given house rent allowance (HRA). Those without this facility and staying in village*

*headquarter are not reimbursed for HRA on time. This acts as a de-motivating factor. Furthermore, equipment and instruments are not supplied regularly. There is no proper storage facility either at the district or at the peripheral level. Five PHCs are inaccessible, and mobility is a problem. There is a short supply of medicines and even basic things required for infection prevention are not supplied regularly. In this condition, it is difficult to provide good quality services. However, we try to provide the best services we can with all these limitations.”*

The views expressed by the CDMO were reiterated by the medical officer of the PHC and subsequently by the ANMs as well.

Since quality of service was one of thrusts of the new approach, we discussed service delivery with functionaries at the PHC and sub-centre levels. In the course of our discussions, we found that both monitoring and supportive supervision in the form of increased numbers of field visits by the health workers and their supervisors had improved, and that weekly meetings at PHCs had been introduced. Other than these measures, no improvements in the quality of services were visible, as no efforts had been made to enhance the technical competency of the staff.

Although the statistical assistants had classified potential clients (potential as identified by the provider after analyzing the age and parity of eligible

#### Box 1

<b>Sterilization</b>	Couples having 3 children plus Couples having 2 children	8% couples to be covered
<b>IUD</b>	Couples having 2 children plus Couples having 1 child	8% couples *3 ----“-----
<b>Condom Users</b>	Couples having 2 children plus Couples having 1 child plus Couples having no children	13/1,000 couples
<b>Pill Users</b>	Couples having 2 children plus Couples having 1 child plus Couples having no children	3/1,000 couples



women) at the sub-centre level, the health workers in the field did not know who their potential clients were despite having well-maintained ECRs. Moreover, they did not have proper knowledge about the correct use of methods, about details of side effects, and about contraindications. Also, stock registers indicated that the sub-centres had not received any iron or folic acid (IFA) tablets for over a year and a half. In such conditions, how far can the new approach go toward improving the quality of services? Note that in spite of these deficiencies, the facility survey of the RCH project was completed, though upgrading existing facilities and adding new ones has not begun.

In reality, TFA has not been properly implemented. Though the state did adhere to the GOI formats, it set procedures for estimating the ELAs for each family planning method because of the void created by GOI when targets were removed. In other words, the procedure for making estimates was decentralized, so Orissa followed its own pattern and implemented the programme in its own convenient way. The responsibility for fixing targets shifted from GOI to GOO, and the districts did exactly what the state government asked them to do. Indirect calculations standardized at the state level were used as the ELAs. If implementing the TFA approach consists merely of submitting GOI activity plans and monthly progress reports, then Orissa has implemented it; this is the understanding of all the officials and health functionaries in the state.

In this context, we asked a few ANMs about their understanding of the TFA approach and the processes of implementation. One ANM in Ganjam district, who had performed better than other workers in the PHC area, offered this explanation:

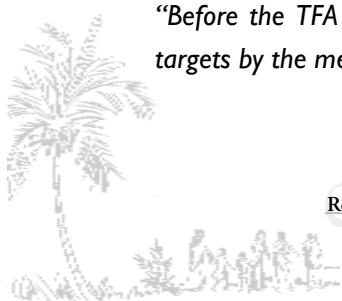
*“Before the TFA approach was introduced, I was given targets by the medical officer, and every month I used to*

*prepare monthly reports and submit them in the meetings. If the monthly targets were not achieved, the medical officer used to demand an explanation. Even now the same thing is done. However, targets are not given directly. Based on the ECR survey, the eligible couples are classified by age and parity before submitting to the PHC. The PHC statistical assistant then examines it and informs me that I will have to perform this number of sterilizations, this number of ....., etc., for the year. These numbers are later broken down into monthly targets. While allotting these numbers, the medical officer says this percentage of women in this parity will have to be covered for this method and so on. Against this, the logistics requirement was estimated and the supplies have been given accordingly. Later, during field visits, I try to contact such women and motivate them. The new thing in this approach is that younger women in lower parities are approached because their profile is available. Further, the monitoring and reporting has strengthened. Weekly meetings are held at sector level and the supervisor visits me more often and helps me in carrying out the determined activities.”*

Another ANM in Khurda district told us this:

*“I got posted to this district from a neighbouring district. I did not see anything different in the way the new approach is being implemented. I have been doing exactly the same thing I was doing there. I was updating the ECR and submitting it to the PHC. The PHC statistical assistant used to do some calculation and then come up with the workload of my centre. According to my workload, I plan my activities along with my supervisor’s help and visit the villages. Earlier I used to be reprimanded if I had not performed well but now I am given a chance to explain and then supportive supervision in the form of more supervisory visits is provided if it is a genuine case.”*

In view of these discussions, it emerges that the most important link in the execution of the new approach





seems to be the statistical assistants because they are the ones who determine activities at the sub-centre level. The ANMs are still unaware of how their workloads are compiled or calculated. Discussions with health functionaries indicated that the pressure to perform well had actually increased because of weekly monitoring from the PHCs. Nevertheless, it can be deduced that Orissa made efforts to implement the approach in its own way and to help health functionaries understand the importance of it.

After reviewing the implementation of TFA, GOI found that due to complex calculations, the health workers were handicapped in fully utilizing the manual and setting performance norms for themselves. Therefore, two workshops were held on August 19 and 28, 1997, in the National Institute of Health and Family Welfare (NIHFW) in New Delhi. Grassroot workers like ANMs and medical officers from PHCs of different states along-with district and GOI officials participated and provided feedback on their experiences and on the effectiveness of the manual as well. Following these workshops, the manual was simplified and was officially introduced in April 1998.

The revised manual, called the CNA, was given to all the states to be used from the beginning of fiscal year 1998-99. Orissa too received the manuals and sent them to the districts asking them to compile information using the new formats. In the absence of any training or orientation, health functionaries (statistical assistants only) started compiling information and submitting annual plans and monthly reports along the lines of the newly designed formats. At the time of our visit, the State Institute of Health and Family Welfare (SIHFW), which was also responsible for training, was translating the manual into the local language. In this regard, we discussed the training itinerary and

its utility with the Director of the SIHFW. The Director mentioned that training was likely to start in January 1999 because the manual had yet to be finalized and copies had to be available at the sessions. The state had already received Rs. 7 lakh from GOI in July 1998, but there had been a delay on the part of the state. The training calendar was to be finalized after consultations with the Directorate and Secretariat. When asked about the utility of training, the director mentioned this:

*“The CNA training in its new form is nothing new except for a few changes here and there. Since the workers were trained earlier, the state thought that it could be implemented without much effort. The state, therefore, sent the monitoring formats to all the districts and asked them to compile information in the new formats. Accordingly, the districts have prepared and submitted the plans to the state. The state plan was completed and sent to GOI in September 1998. However, the main issue is not the CNA manual training as it is only loaded with mathematics. A person good at it can do very well. However, behind the mathematics or the numericals one needs to understand what our goal is and how do we strategize to reach that goal? Earlier we had the “Health for All” or “Reaching Replacement Fertility” by such and such a time frame as our goals. With the introduction of TFA/CNA, nobody is emphasizing it and probably it is forgotten. In the absence of such goals, it is difficult to work out state-level strategies and subsequently the activities to achieve them. This is what has happened in the early years of implementation of the new approach, and we are still continuing doing this. The state has had discussions on this particular issue and is likely to spell out state-specific goals and in accordance try work out an implementation plan. Most probably we will be integrating our RCH package with CNA training as a single package so that the district officials who are the real implementers of the various programmes are not frequently called for various training sessions now and then.”*



Despite delay in implementing the CNA approach, the state has been seriously contemplating integrating various training programmes. Although this is a good idea, there has been no movement in the development of training packages, curriculum, and pedagogic tools to be used. It seems to us that at this pace it will take a long time for such a package to become a reality.

## Family Planning Performance

Overall acceptance of family planning to a large extent declined at the state and at the district levels, though results for specific methods were mixed.

Despite delay in implementing the CNA approach, the state has been seriously contemplating integrating various training programmes. Although this is a good idea, there has been no movement in the development of training packages, curriculum, and pedagogic tools to be used.

The expected and actual levels of sterilization acceptance after the introduction of TFA declined while the acceptance of IUDs and oral pills improved considerably. Condom use, like sterilization, dropped. We offer the following analysis for each method of family planning from 1994-95 to 1997-98.

### Limiting Methods

The sterilization target for the year 1994-95 was 200,000; 162,085 were performed for an achievement rate of 81 per cent. In 1995-96, the target for sterilizations remained the same since Khurda district was not given any targets. The performance during this year dropped by eight per cent from the previous year (148,659 sterilizations

performed). With the introduction of the TFA in the state in 1996-97, the expected level of achievement for sterilization was around 191,513; 134,825 were conducted for an achievement rate of 70 per cent. However, when compared with the overall performance of 1995-96, there was a nine per cent decline. Nearly 23 out of the 30 districts in the state witnessed a considerable decline in acceptance. In 1997-98, acceptance dropped further as only 127,046 sterilization operations were conducted. The overall decline between 1994-1995 and 1997-1998 in sterilization was around 21 per cent.

The ELA for sterilization as depicted in Figure 1 indicate that it has come down from 200,000 in 1994-95 to 177,000 in 1997-98. Instead of ELAs increasing in proportion to population growth and because of annual attrition among users, they have dropped by 13 per cent. This is not good because, in general, lowering ELAs creates a tendency to under-perform as seen in the case of Orissa. The impact of the programme on fertility is bound to suffer due to this, especially in the absence of monitoring the age and parity of new acceptors.

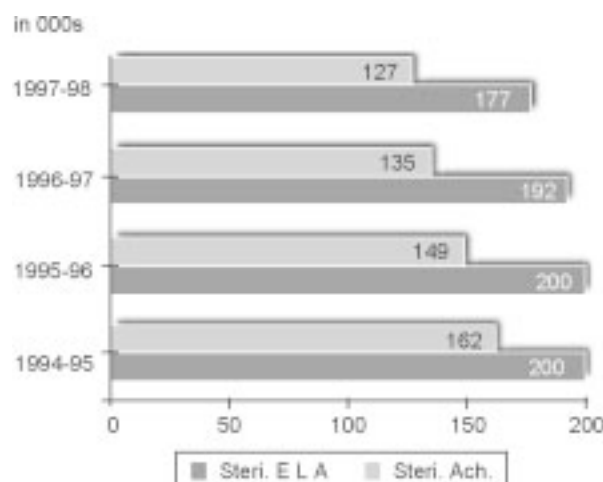
From 1994-98, quarterly acceptance of sterilization uniformly increased from the first to the last quarter each year. In the year 1994-95, more than three-fourths of the sterilizations were done in the second half of the year. Only five per cent of total performance was achieved in the first quarter; this increased to 17 per cent in the second quarter, 34

Table 1  
Expected and Actual Levels of Sterilization Acceptance in Orissa from 1994-95 to 1997-98

Year	Expected Acceptance	Actual Acceptance	Percentage Achievement
1994-95	200,000	162,085	81.0
1995-96	200,000	148,659	74.3
1996-97	191,513	134,825	70.4
1997-98	177,004	127,046	71.8



Fig. 1  
**Sterilization Performance in Orissa**



per cent in the third quarter, and 44 per cent in the fourth quarter. A similar pattern of performance is observable for subsequent years even after the introduction of the TFA in 1996-97.

It can, therefore, be inferred from Table 2 and Figure 2, that though enormous changes were made in the planning process to implement the new approach, actual performance seems to be more or less similar to what it was before its introduction. Nearly three-fifths of operations continued to be done in the latter half of the year.

### Spacing Methods

In 1992, the National Family Health Survey (NFHS) found that less than one-tenth of acceptors of modern contraceptives were using a spacing method in Orissa. As a majority of the population is in rural areas with limited accessibility to public health

services, provision of spacing methods on a continuous basis is a problem despite the fact that there is more unmet need for spacing than for limiting. The government, therefore, has made considerable efforts to provide these services. As expressed in the service statistics in Table 3 below, the acceptance of IUDs and oral pills has improved dramatically over the years as a result.

### IUDs

In 1994-95, 193,582 new acceptors of IUDs were recruited; in 1995-96, the number was 209,074. With the expansion of the TFA to the entire state in 1996-97, acceptance dropped by eight per cent compared with 1995-96. In 1997-98, the ELA was increased drastically following the letter of Additional Secretary (Family Welfare) of Orissa. As a result, performance also improved substantially. Thus, between 1994-95 and 1997-98, acceptance improved by 27 per cent. This was possible because of close monitoring by the department staff and the secretariat as well.

### Oral Pills

The number of oral pill users in the state was 93,904 in 1994-95. Unlike the acceptance of sterilization and IUDs, in 1995-96 pill acceptance improved over the previous year by six per cent. In 1996-97, there were 106,472 users. In 1997-98, acceptance rose by just over one per cent over the past years performance but in comparison to the base year 1994-95, there was a 15 per cent increase. Acceptance increased in all districts in the state

Table 2  
**per cent Distribution of Sterilization by Quarter in Orissa from 1994-95 to 1997-98**

	1994-95	1995-96	1996-97	1997-98
1 <sup>st</sup> Quarter	5.0	4.5	4.1	4.6
2 <sup>nd</sup> Quarter	17.3	18.1	16.8	15.8
3 <sup>rd</sup> Quarter	33.8	33.0	34.0	34.8
4 <sup>th</sup> Quarter	43.9	44.4	45.1	44.8



Table 3

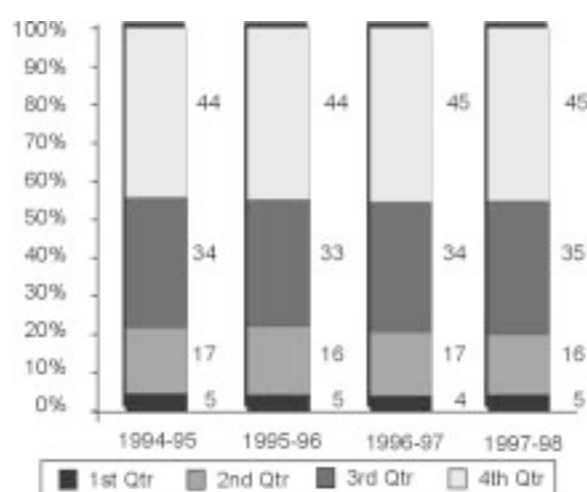
**Annual Performance and Percentage Increase/Decrease of Spacing Methods in Orissa from 1994-95 to 1997-98**

Year	IUD		Oral Pills		Condoms	
	AP	PI/PD	AP	PI/PD	AP	PI/PD
1994-95	193,582	---	93,904	---	467,838	---
1995-96	209,074	8.0	99,731	6.2	443,483	-5.2
1996-97	193,167	-0.2	106,472	13.4	369,528	-21.0
1997-98	245,693	26.9	107,722	14.7	255,967	-45.3

AP= Annual Performance; PI/PD= Percentage Increase/Percentage Decrease over the base year 1994-95

Fig. 2

**Quarterly Sterilization Performance from 1994-95 to 1997-98**



from a minimum of three per cent in Bolangir district to a maximum of 65 per cent in Phulbani district.

It should be noted that GOI sets targets in terms of the number of oral pill-users but monitors acceptance in terms of the number of cycles distributed. In doing so, very important, crucial information on dropout rates and duration of use that could be analyzed in the various registers is generally overlooked. Consequently, calculations are restricted to numerical achievements without considering quality issues. Wastage is not accounted for, and in the final calculations, the actual numbers get inflated.

Furthermore, oral pill acceptance largely depends on supply. It has been observed that the supply of pills is not actually driven by demand. In fact, an increase in the number of users directly depends on the quantity of supplies received and distributed. To find out the precise situation, we analysed stock data in Khurda and Ganjam. It revealed that the distribution to the districts from the state fluctuated considerably. For instance, the supply to Ganjam in 1996-97 fluctuated from a minimum of 5,000 cycles to a maximum of 40,000 cycles per month, and the quantity increased in the last quarter of the fiscal year. In 1996-97, an average of 8,000 cycles was distributed each month though it varied from 1,000 to 14,000 cycles. A similar pattern of distribution was observed in Khurda district. Given these fluctuations, the methodology for calculating users based on numbers of cycles distributed is questionable. Reported figures are likely to be inflated rather than based on actual use. The lack of information on continuous users is a major constraint to reaching any conclusions on the actual number of users of oral contraceptives.

### Condoms

The calculation of condom users is done on similar lines as that of pill-users, and identical problems exist in the calculation of regular users, continuation and dropout rates, and so on. In 1994-95, there were 467,838 condom-users. That number decreased by about five per cent in 1995-96. The



trend continued in the following years until in 1997-98, acceptance was about 70 per cent of that in 1996-97. Overall, when compared with the period prior to and after the introduction of the new approach, the decline in performance was over 45 per cent, and districts that had been performing well fared badly.

Regarding the supply of condoms, the quantity distributed by the state to the districts and by the districts to other centres varied from month to month. For instance, Khurda received 360,000 condoms in the beginning of April 1996, and it distributed 162,000 condoms by the end of the month. In May, Khurda did not supply condoms to any PHCs. In June, Khurda received 420,000 condoms and distributed only 54,000. None were supplied or distributed until the end of November. In December, however, 24,000 condoms were distributed against a receipt of 60,000 from the state. In January, the district received 12,000 and distributed all of them. The fluctuation in receiving and distributing condoms reinforces the fact that condom use is supply driven; generally, higher performance was reported when supplies were abundantly available while lower performance was reported for months when there was less stock.

## Conclusion

Orissa has been making efforts to provide a basic package of health services to its people by streamlining its existing health service delivery system, but the formation of 17 new districts has put additional pressure on the meagre health budget of the state. Hence, the state determined its priorities and financial deficits and later negotiated with various donor agencies to plug the shortfalls. To facilitate this process, a coordination cell for implementing projects funded by donors was set up, but it has yet to function. In this context, the state was forced by GOI to implement the TFA

with the expectation that it would improve the quality of services.

The state has implemented the TFA in accordance with GOI instructions. Since it was introduced late, only state-level training could be conducted in the first year. Due to this delayed beginning, the approach could not be field-tested, yet the activity and monitoring forms that should have been introduced after field-testing were put into use. A similar situation existed in case of the revised approach extended to all districts. The training of functionaries was not carried out in a systematic way. Even to this day, two or three districts have not done any CNA training, and the Directorate has remained silent about it.

Furthermore, the technical competency of the workers has not been assessed, and very few efforts have been made to improve the quality of services. The procedure for setting targets shifted from the central government to the state, and the state formulated its own procedures for working out ELAs in the void created by the GOI. The client's perspective, which is the underlying force of the new approach, has not been considered in TFA implementation. The programme has remained a provider's programme, thus defying the basic principles of bottom-up planning.

During this period, family planning acceptance, particularly that of sterilization and condoms, dropped substantially, but there was remarkable improvement in that of oral pills and IUDs. Acceptance of IUDs declined in the first year of the new approach, but went up in subsequent years because of measures taken by the state. Information on age and parity of acceptors that is available at the

---

The state has implemented the TFA in accordance with GOI instructions. Since it was introduced late, only state-level training could be conducted in the first year.

---



department has not been analyzed though the ELAs have been calculated based on parity.

In addition to all this, the GOI mandated RCH programme is in its infancy, and its functionaries are yet to be trained in the revised CNA approach. Even

though the think tank at the state level favours the integration of RCH with the CNA approach, very little has been done in that regard. If this thinking is translated into action, then only a change for the better can be expected, but that does not seem to be forthcoming in the near future.



# Community Needs Assessment Approach for Family Welfare in Rajasthan



Hemant Dwivedi  
Daya Kishan Mangal  
Gadde Narayana



## Introduction

Rajasthan is one of the largest Indian states, constituting 5 per cent of the total population and 11 per cent of the land area of the country. The state is divided into 32 districts which are grouped into 6 administrative divisions. The total population of Rajasthan in 1951 was 16 million and increased to 44 million in 1991. Rajasthan is one of the major states in India with high infant mortality, maternal mortality and fertility rates. The total fertility rate of Rajasthan at 4.1 in 1997 is double than that of replacement level of fertility. According to the population projections prepared by the Expert Group constituted by the Registrar General of India, based on pace of decline of total fertility rate in the past 10 years, Rajasthan is likely to achieve replacement level of fertility only in 2049.

The socio-economic conditions acted as main barriers to the use of modern contraceptive methods in Rajasthan. Even after considerable effort made by the Government of Rajasthan and several voluntary agencies, the female literacy at 20 per cent is the lowest in the country. Nearly 82 per cent of women in child bearing age are illiterate. Child marriages and low status of women are other contributing factors. Realizing the need to achieve population stabilization as early as possible, the Government of Rajasthan initiated several measures to reform reproductive child health program management in the past 5 years, even before the introduction of target free approach in the county. The main aim of these initiatives is to explore alternate approaches to services delivery, to increase access to and quality of reproductive and child health services. Rajasthan Government has reviewed these new systems from



time to time, scaled up the successful interventions and discontinued the less successful ones.

## Objectives of the study

The main objective of this study is to document the experiences of implementing reproductive child health program in Rajasthan in 1997-98 and 1998-99 in the context of implementation of target free approach. The study has analyzed the new innovative strategies and interventions introduced to improve efficiency and effectiveness of program implementation. In addition, program managers at

various levels in the organization were interviewed on issues related to implementation of new strategies. Performance of Rajasthan family planning program for the past three years has been analyzed.

## Unmet need and decentralized planning

The program administrators, particularly the Secretary of Family Welfare in Rajasthan, in 1994-95, much before the introduction of the target free

approach, decided that the unmet need for family planning services should be the focal point of all program implementation efforts. From then onwards, the program emphasis was largely on annual surveys of all eligible women by health workers at sub-centre level to identify the unmet need for both spacing and terminal method use. For this purpose, the Eligible Couple Survey Register was comprehensively reviewed and redesigned. All workers were trained on how to collect and analyze the information. The Service Delivery Registers were designed to record the names of currently married women with unmet need for each method of family planning. These booklets have become

very effective mainly to provide services to women with unmet need and also have become effective tools for monitoring program performance. The orientation training programmes were conducted in April 1997 in all 31 districts of the state. A team of trainers consisting of the Joint Directors and Demographer visited all districts and conducted training to workers in groups. These training programmes concentrated on how to collect accurate information at household level, how to compile collected information and how to convert information into micro plans. Progress of training, data collection and preparation of micro plans were closely monitored by the Secretary (Family Welfare) and the Director (Family Welfare). In the year 1997-98 special emphasis was placed on survey of couples in urban slums. As per the guidelines drawn by the department, the workers are expected to complete the survey work in the month of May. The primary health centres are supposed to consolidate the unmet need identified in all subcentres in the first two weeks of June and the district level plans, by the end of June. In effect, the unmet need identified in the month of May of every year becomes the annual expected performance of the workers or a micro plan for subcentre, and annual plans for primary health centres and districts. Program performance monitoring is done based the extent to which the unmet need for family planning has actually been met.

To overcome the problem of fudged performance reports, the department had introduced concurrent evaluation by external survey research agencies in 1995-96. The investigators from these agencies collect information from randomly selected households in villages and report on the actual performance and also reasons for non-use of family planning methods by couples who have unmet need. This considerably helped to improve the quality of service statistics in the state. After two

---

The programme administrators, particularly the Secretary of Family Welfare in Rajasthan, in 1994-95, much before the introduction of the target free approach, decided that the unmet need for family planning services should be the focal point of all Programme

---





years, in 1998, the concurrent evaluation was discontinued and more emphasis was laid on the regular monitoring.

In the year 1997-98, program emphasis shifted more towards creation of demand for spacing method use among young married couples, and to ante-natal care services and immunization coverage. The Secretary (Family Welfare) in a letter written to all Division Commissioners, District Collectors, Joint Directors, Chief Medical and Health Officers on December 1997 stated:

*“ I would request that special attention be paid to the family welfare programme in view of limited time at our disposal. I would like to reiterate our view, expressed from time to time, that instead of the target free approach, Rajasthan is following the system of self assessed target (SAT) where in ANMs have gone from house to house in the months of April and May and ascertained the reproductive health and coverage needs of all the eligible couples residing in the villages of their subcentres. This confusion with regard to target or lack of target must be finally resolved and closed as from our point of view, it not a useful debate. Suffice to say that since targets have not been imposed either from Delhi or Jaipur as was the case earlier, but is reflective of results of the house to house to survey conducted by the ANMs, they are a reflection of the service requirements that must be delivered by our medical and health infrastructure.*

*You will yourself see, there is a strong emphasis on spacing methods, especially IUD insertion as well as measures to check reproductive health disorders through Mahila Swasthya Melas. The minimum level of achievement expected from you, however is only a fraction of the actual need as expressed by eligible couples in their reproductive cycle. I trust you will have no problem in evolving a suitable strategy for achieving the minimum level, which is realistic and attainable.”*

In the year 1997-98, Rajasthan Government involved the district collectors in program implementation particularly to establish coordination linkages between workers of different departments and to monitor program performance on a regular and continuous basis. The Commissioners at divisional level and the Secretary, Family Welfare called for the meetings of district collectors to brief them about the program objectives and the strategies and also to review the issues involved in implementation. For instance, the Chief Secretary of Rajasthan in a letter to all district collectors stated the areas which need special attention to improve performance:

1. As per the district micro plan, the individual institution should be the basic unit for programme monitoring.
2. The doctors and field functionaries who have not acted sincerely for improving programme performance should be held responsible for poor performance.
3. The eligible couples with unmet need of limiting for family planning should be contacted properly and services shall be made available to them.
4. It has to be ensured that surgeon team reaches at camp site in time.
5. The acceptors of spacing methods should get regular supply of methods
6. In our state IMR is increasing since the last three years. So far as service statistics of immunization is concerned the coverage level is more than 90 percent, but increase in IMR put a question mark on those figures. The following points are to be taken care in the immunization programme:



- All pregnant women should be registered for ANC services, in this the health worker should see the population and birth rate of the area for making projection of expected deliveries
- It should be ensured the children are immunized at right time
- Special emphasis should be given to institutional deliveries, the untrained dais are to be trained in order to increase deliveries by trained hands.

---

Rajasthan continued with several of its innovative approaches launched in the early 1990s and added a few more and scaled up some during 1997-99.

---

The Secretary, Family Welfare held several meetings with the chief medical and health officers, the deputy chief medical and health officers, and the district maternal and child health officers to stress on the importance of supportive supervision and programme monitoring.

Monthly feed back system was established based on review of program performance in 1998-99. The Secretary (Family Welfare) and the Director (Family Welfare) reviewed the previous month performance of every district during the first week of every month. The review is based on objectives set by the districts for themselves for the year. Feed back based on review was sent to the District Collectors by the Secretary (Family Welfare) and to the Chief Medical and Health Officers and the Deputy Chief Medical Officers by the Director (Family Welfare). Based on the comments, the district collectors conducted the meetings of PHC medical officers who in turn reviewed the performance of the subcentre staff. These meetings were also utilized to develop district specific information, education and communication strategies to generate more demand for services.

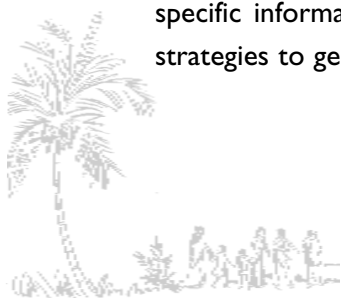
In addition to the above, bi-monthly review of program implementation was introduced in 1998-99. Supervisory teams of state level officers were constituted and each team was given a cluster of districts to monitor program performance in each district on bi-monthly basis. These supervisory teams made regular visits to all districts in their designated areas and submitted the reports to the Secretary (Family Welfare). These reports formed the basis for bimonthly program performance review conducted by the Secretary (Family Welfare) for all Chief Medical and Health Officers.

### **Innovative approaches**

Rajasthan continued with several of its innovative approaches launched in the early 1990s and added a few more and scaled up some during 1997-99.

#### **Jan Mangal**

Jan Mangal program has been expanded rapidly to cover 12,000 villages. This is a program implemented through volunteers selected from villages. Jan Mangal volunteers are a couple who are current users of family planning. They serve as information providers for population of approximately 1,000 and also act as depot holders for spacing methods. The department after selection provides them training for a period of three days. These couples contact eligible women on regular basis and counsel them about family planning methods. They also supply ORS packets to those who are in need. The PHC MOs conduct a meeting of volunteers once in two months to provide them IEC material and also replenish the stock of contraceptives. There is no monetary compensation given to Jan Mangal couples but they are encouraged to charge fixed service fee for contraceptives distributed. The scheme, to begin with, was tested in Udaipur district and scaled up to cover 12,000 villages.



### **Ayur Swasthya Karmi Scheme**

This scheme has been promoted to involve the practitioners of Indian Systems of Medicine. Many of the tribal districts in Rajasthan do not have qualified medical practitioners in private sector. The health personnel of public sector, even if posted, are reluctant to stay in tribal areas. A large proportion of positions of public health sector, as a result, have remained vacant for long periods of time. Given this, the department thought it appropriate and necessary to involve ISM practitioners who live in tribal areas and provide services to tribal people in implementation of reproductive and child health program. Jhadol block in Udaipur district was selected for the purpose on an experimental basis in 1997-98. The Indian Medicine Board has been selected as an implementing agency. The ISM practitioners were trained to provide maternal and child health services to tribal population. No evaluation of the project has been done so far.

### **Involvement of Elected Panchayat Leaders in Family Welfare Program**

During 1997-98, special efforts were made to involve elected representatives of Panchayat Raj and Municipal Councils. In November 1997, in every district one workshop was organized for elected representatives of rural and urban bodies. The training programmes dealt with various services provided by health department and the need to achieve population stabilization. Each program was attended by a team officers from the state level including the Secretary (FW) and the Director (FW). In addition to this, active linkages were established between panchayat members and health service delivery functionaries at various levels. Rajasthan has constituted Mahila Swasthya Sangh in each village to share information and to promote utilization of health services. Elected women members of Gram Panchayat were made ex-officio members of the Mahila Swasthya Sangh. Similarly participation of the

medical officers of the primary health centres and community health centres in the monthly meetings of elected representatives at Panchayat Samiti was made compulsory. As a result of these efforts the interactions between elected representatives and health personnel at various levels improved considerably. More systematic and institutionalized effort is required to convert interactions into effective participation.

### **Tetanus Toxoid Campaign**

One of the significant steps taken by the Rajasthan Government in 1998-99 was to conduct TT campaign for women. The infant mortality rate in Rajasthan showed no appreciable decline in the past five years. Nearly 8 out every 100 children die before reaching 12 months age. Neonatal tetanus mortality continued to be one of the key contributors of infant mortality. Only 28 percent of pregnant women received TT injections in 1992-93 and 43 percent in 1996.

More than half of the mothers did not receive any TT coverage. Given this, the department considered it essential to increase the TT coverage of women following campaign approach. The campaign approach helps to mobilize all possible resources to a limited period and gives a very high visibility to the service. The main objective of this campaign approach is to provide two doses of TT vaccine at an interval of 4 to 5 weeks to all married women in the age 15-30, irrespective of their previous immunization status.

---

The main objective of this campaign approach is to provide two doses of TT vaccine at an interval of 4 to 5 weeks to all married women in the age 15-30, irrespective of their previous immunization status.

---

To begin with a planning meeting at state level was organized in February 1998 to prepare the operational guideline for the campaign. Following this, district and block level meetings were held in the same month to discuss the details of campaign



approach. A detailed logistic plan was prepared to keep the supply chain active.

Village contact surveys were conducted in all villages of the state in the month of March with the help of subcentre health workers and all married women in age 15-30 were enumerated. A similar survey was conducted in all slum areas of 6 major towns in Rajasthan. Based on total women in age 15-30, the total vaccine requirement was calculated. In addition, estimates were done for sterilized syringes and needles, pressure cookers, drum sterilizer, kerosene

oil, vaccine carriers, and stationery. Immunization sites in each village were identified in advance. Immunization teams were constituted, each team consisting of one supervisor and two workers. Each team was given responsibility of covering a cluster of villages and a route map was prepared and date on which immunization camp was to be held was worked out. All

pregnant mothers immunized in each village were given disposable delivery kits.

Information, Education and Communication Bureau of Rajasthan health department designed and printed publicity material such as banners, posters, hand outs, pamphlets, booklets and wall paintings. TV shows, panel discussions, radio talks, press briefings were organized to create awareness about the campaign. Other departments such as Panchayati Raj, Women and Child Development, Rural Development and Education departments were involved in mobilization of women in each village. Jan Mangal couples and Mahila Panchs were involved to contact and share information with married women in the age group.

The first round of campaign was done from April 20-26 and the second round of campaign was done from May 24-30, 1998. Nearly 3.5 million women in child bearing age of 15-30 (80 per cent) were given two doses of TT injection.

### **Community Awareness Generation Programmes**

The Ministry of Health and Family Welfare, Government of India advised Rajasthan to conduct community awareness generation programmes for health personnel at subcentre level. Rajasthan decided to conduct these programmes not only to health personnel but also to anganwadi workers, elected women punch and surpunch, school teachers and other local influential persons. Three resource persons, two from external agencies and one from health department were identified for each district. Three day training of trainers programs were conducted for the resource persons. In all 1,646 training programs were conducted at sector PHC level between December 1998 to February 1999.

The training sessions covered population issues, reproductive health issues of adolescents and women, child health, family planning, and STD/RTI/AIDS. The Government of India provided the RCH booklet and the Manual for Community Needs Assessment as training material. While sufficient financial resources were made available for training programs, no money was given for printing and distribution of training material. Due to this, the training material could not be distributed. There was also no follow up after the training programs. Rajasthan has decided to retain its own system of identification of unmet need than follow the new system proposed by the Government of India under the community needs assessment.

Rajasthan decided to conduct awareness generation programmes not only to health personnel but also to anganwadi workers, elected women punch and surpunch, school teachers and other local influential persons.



### **Rajasthan Population Policy**

Another significant step taken by Rajasthan was formulation of a comprehensive state population policy which was approved by the Cabinet on July 31, 1999. One of the main objectives of the policy is to reduce total fertility rate from 4.1 in 1997 to 2.1 in 2011. For this, Rajasthan proposes to increase the contraceptive prevalence rate from 32.1 in 1997 to 65.9 in 2011. The second major objective is to reduce infant mortality rate from 85 in 1997 to 53.8 in 2011. The main strategies to achieve these objectives revolve round increase in age at marriage, gender equality and empowerment of women, contributions by various development department, involvement of panchayati raj institutions, non-government organizations, and private and corporate sector and effective management of family welfare program.

Rajasthan proposes to review and reorganize the health department to improve demand for and quality of services, involve elected leaders in decision making, revamp information and supply systems, and encourage operations research. The health department is now preparing an elaborate implementation plan for each component of policy with details of what should be done and responsible person to do it.

### **Opinions of health personnel on target free approach**

Personnel of health department at various levels were interviewed to elicit their opinions on the target free approach, renamed as the community needs assessment approach. The Secretary (FW) feels that the new approach will be successful only when program monitoring mechanisms are strengthened and only when the interventions are client oriented. She felt that the regular review and monitoring of family welfare program and coordination links with other development departments has considerably improved the performance in 1998. According to

her, convergence of services at local level is essential for the success of the program. She also opined that more importance should be given to dai training and supply of disposable delivery kits to pregnant women in rural areas. Interventions such as TT campaign conducted in the state to reduce IMR and MMR, she thought, would have a major impact on acceptance of services and increased use of modern methods of family planning.

The Director (FW) felt that Rajasthan has improved its performance mainly due to the survey and micro-planning approach followed. Because of the compulsory annual surveys, the health workers' contacts with workers improved and also services provided to clients. The client survey provided a clear understanding of the reproductive health needs in a subcentre area. He said that frequent transfer of medical officers is a major obstacle in successful implementation of the program.

---

The Director (FW) felt that Rajasthan has improved its performance mainly due to the survey and micro-planning approach followed. Because of the compulsory annual surveys, the health workers contacts with workers improved and also services provided to clients.

---

The district level officers of both Tonk and Ajmer felt that identification of unmet need resulted in better monitoring and program performance. They thought that the decision to abolish incentives scheme led to better quality of services with emphasis on client needs. According to them, the spacing method users have not increased significantly. They attributed this to non-availability of male workers or low participation of male workers in family planning program implementation. There was considerable improvement in quality of data collected and feed back given on performance. Improved program management skills is essential, according to district and PHC medical officers, to achieve objectives of



the program. The female health workers viewed the new system when it was introduced with some amount of distrust. Door to door survey to identify unmet need was considered a cumbersome process without any commensurate benefit. After a couple of years, they felt that the new system was very helpful not only to focus their efforts specifically on clients with unmet need which helped them achieve better results.

### Family planning performance

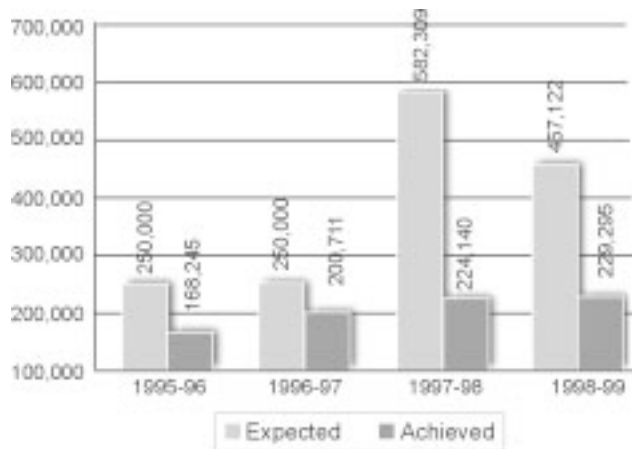
Family planning performance based on service statistics has been compared for the past four years for each modern method. While service statistics in general are reliable for sterilization method, their reliability for spacing methods is low.

### Sterilization Performance

The emphasis on sterilization has remained the same even after the introduction of unmet need approach mainly because the number of couples with unmet need to limit is very high in Rajasthan. The state imposed targets in 1995-96 and 1996-97 for sterilization method remained the same at 250,000 sterilizations per year. Only in 1997-98 and again in 1998-99, the estimated unmet need identified based on household survey done by female health

workers was considered as expected level of performance. The number of couples with unmet need for sterilization as a result increased to 582,309 in 1997-98 and 457,122 in 1998-99. As a result, the actual performance as proportion of expected performance has actually declined compared to previous two years. However, the performance in actual terms has increased considerably in 1997-98 and 1998-99. The sterilization performance in the past four years showed an upward trend. The total sterilizations done in 1995-96 were only 168,245 and the performance in 1998-99 was 229,295 sterilization operations, an increase of about 37 percent and an average annual increase of 12 percent. Given the high unmet demand for sterilizations, there is still scope to improve the performance. Rajasthan has decided to provide sterilization services in more health institutions which will increase the access to services. With increased access, the number of acceptors is likely to go up. Another significant aspect is that performance is not uniform in all districts. While some districts have increased the performance levels, others have not shown any improvement. These differentials have to be taken into consideration to evolve effective district level service delivery strategies.

Fig. 1  
Sterilization Performance in Rajasthan

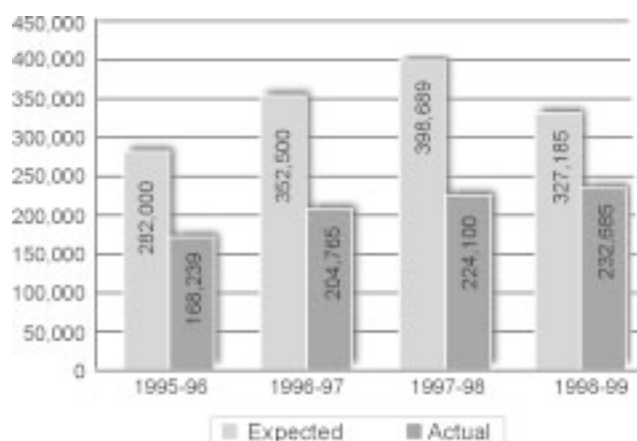


### IUCD Performance

Number of IUCDs inserted also showed a marked increase in the past four years. In 1995-96, the expected performance was 282,000 IUCD insertions and achievement was 168,239 insertions. In 1998-99, the expected performance increased to 327,185 insertions and the actual performance was 232,685. As has been the case with sterilizations, the expected performance of IUCD has increased considerably over a four year period. The actual performance has also kept pace with rising expectations.



Fig 2  
IUCD Performance



The monthly performance reports of districts clearly indicate that the emphasis on unmet need has not resulted in reliable reports for spacing methods. For instance, Pali district which has reported the highest IUCD performance in the year 1997-98 has shown considerable fluctuations in month wise performance.

#### Oral Pill Performance

In Rajasthan, the expected level of achievement was 125,000 oral pill users in 1994-95 and that substantially increased to 385,540 users in 1997-98. In the following year, the expected level declined to 328,640 users. Oral pill performance has dramatically increased from 92,268 users in 1994-95 to 484,067 users in 1996-97. After this the reported performance showed considerable decline.

There were only 325,465 users of pills in 1998-99. The extent of achievement of expected level of performance also varied from 74 per cent in 1994-95 to 215 per cent in 1996-97. The performance reported indicates that more the expected level of achievement in a given year, more the performance reported, which is to a large extent an indication of fudged numbers.

#### ELA : Expected Level of Achievement Condom Performance

The expected level of achievement for condoms was 677,000 users for 1994-95 and of this, 70 per cent was achieved. The Health and Family Welfare Department decided not to have any expected levels of achievement for 1995-96 and 1996-97. The performance nevertheless steadily and significantly increased by almost 50 per cent in 1996-97 compared to performance in 1994-95. In the following years, the Department again decided to reintroduce expected levels of performance for condoms. In 1997-98, 341,055 users were expected but the actual performance reported was 470,874 users. The expected level of performance remained more or less same for 1998-99 but the actual performance declined to 374,345 users. Like the reported performance on pill users, the condom users performance was more related to quantity of condoms supplied in a particular year than the actual users.

Table 1  
Expected and Actual Levels of Performance of Oral Contraceptives and Condoms in Rajasthan :  
1994-95 to 1998-99

Year	Oral Contraceptives			Condoms		
	ELA	Achievement	Percent	ELA	Achievement	Percent
1994-95	125,000	92,268	73.8	677,000	475,272	70.2
1995-96	150,000	125,230	83.5	—	519,048	—
1996-97	225,000	484,067	215.1	—	720,414	—
1997-98	385,540	402,489	104.4	341,055	470,874	138.1
1998-99	328,640	325,465	99.0	353,567	374,345	105.9



## Conclusion

Rajasthan faces a formidable task of reducing fertility by 2016 as per the population policy approved by the Government. Low levels of economic development, low status of women, and early age at marriage in Rajasthan are not conducive to the achievement of objectives. Problems are further compounded by the fact that the service delivery systems are ill equipped to provide quality services. Rajasthan Government with committed administrators at top level has taken a series of innovative steps particularly in school education and health to improve the quality of life of its people.

The pioneering effort done with the help of camp approach to provide antenatal services to pregnant women is a major step taken and will definitely help to reduce maternal and infant mortality and morbidity.

Rajasthan RCH programme particularly revolves round the concept of unmet need for family planning. Field workers contact eligible couples and ascertain whether the need for family planning services has been fulfilled or not. The unmet need identified is converted into

expected levels of performance and the actual performance is measured against this indicator. The unmet need concept at least prompts workers to visit households in their area once a year. However what is not known is the extent to which the programme has succeeded in converting the unmet need into demand. The Family Welfare Department has not done a systematic review of this strategy. The latest evidence on the subject has indicated that a large number of couples without unmet need at a given point of time become couples with unmet need

and vice versa. The unmet need is a dynamic concept and the programme strategies have not taken this aspect into consideration. Given this, unmet need is a more reliable tool for advocacy than programme implementation.

Rajasthan Government has introduced several innovative schemes in a limited area and scaled up a few successful elements. Lack of innovative approaches is a major problem in centrally run social development programmes and equally problematic is the proliferation of innovative schemes without systematic efforts to identify successful elements and clear strategies to scale up successful elements. Rajasthan to a large extent belongs to the latter category. There are too many innovative programmes but little effort has gone to consolidate the gains and expand the key innovations.

Rajasthan in the past two years has shifted its focus to a more comprehensive package of reproductive and child health services. The pioneering effort done with the help of camp approach to provide antenatal services to pregnant women is a major step taken in this direction and will definitely help to reduce maternal and infant mortality and morbidity.

Service statistics on oral pill and condom performance is as less reliable as it was before in spite of the fact that the expected levels of achievement are based on unmet need. Remedial measures have to be more systematic than cosmetic. Rajasthan Government should re-introduce the system of concurrent evaluation with external agencies to rectify the situation.





# Community Needs Assessment Approach for Family Welfare in Uttar Pradesh

J.S.Deepak



## Background

Uttar Pradesh is one of the largest states in India, constituting one-tenth of the total land area of the country. It is presently divided into 83 districts that are grouped into 18 administrative divisions. Nearly 80 per cent of the population lives in rural areas, and agriculture is the single largest occupation employing 72 per cent of the labour force. Agriculture also accounts for 46 per cent of the state's income. Uttar Pradesh ranks third in India in terms of both the per capita production of food grains and the growth rate of the production of food grains.<sup>1</sup>

According to the 1991 census, the population of Uttar Pradesh was 139 million. The birth and death rates were, in general, higher than the average rates for the country as a whole. The total fertility rate was 6.6 in 1971, but it declined to 4.0 in 1997. The age patterns of fertility in the last 20 years have shown some positive changes as the contribution to the population size of women aged 30 years and above has been steadily declining. The crude death rate declined from 20 in 1971 to 8.1 in 1998. The modern contraceptive prevalence rate in Uttar Pradesh was six per cent in 1971 but increased to 22 per cent in 1999. Of the total number of modern contraceptive users, 71 per cent are users of limiting methods, and the remaining 29 per cent are users of spacing methods.<sup>2</sup>

<sup>1</sup> National Family Health Survey: Uttar Pradesh, Population Research Centre and International Institute for Population Sciences, Mumbai, 1992

<sup>2</sup> National Family Health Survey (Preliminary Report): Madhya Pradesh, International Institute for Population Sciences, Mumbai, 1999 and Sample Registration System, Registrar General of India, 1998



The Government of India (GOI) followed a target-based approach to family planning from the inception of the programme. Targets for each method were assigned to the states and subsequently were distributed to district and lower levels. Monitoring was based on the achievement of the targets given to each state. Over a period of time, however, service statistics indicated that the contraceptive prevalence rate had increased without a corresponding decline in the fertility rate. The GOI, therefore, called for a meeting of all secretaries in charge of family welfare programmes on April 3 and 4, 1995, and decided to exempt at least one district in each state from targets to explore various alternatives to monitoring programme performance.

### Objectives of this Study

The main objective of this study is to document experiences with the implementation of the Target-Free Approach (TFA). The specific objectives are the following:

- To describe the processes followed to implement the new system
- To record the opinions of personnel on the new system and on the implementation processes
- To analyze the implications of new system on performance.

Personnel at various levels directly concerned with the implementation of the new system were interviewed. Varanasi was selected to collect data at the district and sub district levels. As part of the methodology, one Community Health Centre (CHC)/Primary Health Centre (PHC) and two subcentres in Varanasi were randomly selected. All concerned health personnel in the selected institutions were interviewed with the help of an

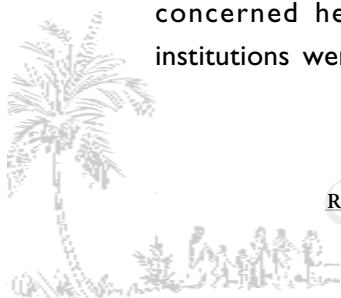
interview guide. Correspondence and other documents available with the Department of Health and Family Welfare were analyzed.

### The Experimental Phase: 1995-96

Agra and Sitapur were chosen as the experimental, target-free districts by the state administration. Agra was selected because it was among the better performing districts in family planning. Sitapur, on the other hand, traditionally had not performed so well, but it was a focus district of the State Innovations in Family Planning Services Agency (SIFPSA). SIFPSA adopted three blocks in Agra and five blocks in Sitapur for initiating operations research (OR) to strengthen programme management under the target-free approach. The Population Council provided technical assistance to the OR Project in these two districts.

The OR Project followed two broad interventions: adoption of the pregnancy-based approach (PBA), and addressing unmet need to implement the (TFA). In the PBA, the Auxiliary Nurse/Midwives (ANMs) were expected to identify all pregnant women in their areas of work and to make three visits to provide antenatal and post-natal services. While the PBA focused on pregnant women, the unmet need approach addressed all women who did not want a child at all or who wanted a child after two years. To implement these interventions the following occurred:

- A modified Eligible Couple Register (ECR) to identify the women with unmet needs was introduced
- ANMs were given a one-day, intensive, in-service training course emphasizing identification of couples with reproductive intentions and how the ECR could be used for planning their work more efficiently



- A laminated sheet describing ways to use ECR information was provided to improve the knowledge of the ANMs about the areas they serve
- The need to upgrade service delivery points was analysed and the centres were equipped according to government norms
- The need for training was assessed and training was carried out
- Changes in the style of review meetings were introduced
- Procedures for the regular monitoring of ANM performance were worked out in detail
- Training in supportive supervision was carried out
- Local women volunteers for every 50 households were recruited to establish links between eligible women and ANMs, and a day, place and time for increasing interaction between the ANMs and the community were worked out.
- Reproductive Tract Infection (RTI) case management services were integrated into PHC responsibilities
- The ANMs were trained to use two logbooks to better manage services according to clients' needs.

Initially, there was resistance and a lack of understanding of the new approach among district functionaries. They strongly believed that family planning targets were essential to get the work done

at the grassroot level; however, with constant and repeated orientation, they started appreciating the importance of the approach. Though family planning performance declined drastically in both districts after the introduction of the TFA, a slight improvement in MCH services was observed.<sup>3</sup>

### **Implementation of the Target-Free Approach**

On February 1, 1996, GOI called a meeting of State Secretaries to announce the expansion of the TFA to every district in the country. There were several drawbacks to this plan.

- The decision was made without reviewing the experiences of the experimental districts in 1995-96
- There were no definite guidelines at the Directorate level for implementing the TFA, so districts followed at least two different methods. A few districts, like Varanasi, took a complete census of all Eligible Couples (EC) to estimate reproductive health needs. Other districts undertook surveys in 10 sample villages to arrive at estimates for each village
- The training given to the workers and supervisors was neither uniform nor systematic, so most workers reached the conclusion that “no target meant no work”
- The TFA manual had not been translated into Hindi.

Thus, in the year 1996-97, the TFA in the real sense was not implemented in Uttar Pradesh. The family planning programme was deleted from the 20-point

<sup>3</sup> “End-of-Evaluation of the Operations Research Project in Agra and Sitapur”, The Population Council, New Delhi, 1999

<sup>4</sup> Narayana, Gadde, “An Analysis of Policy Change, Consequences and Alternative Choices”, Targets for Family Planning in India, The POLICY Project, The Futures Group International, New Delhi, 1998



programme, and district magistrates were no longer directly responsible for monitoring performance as they had been before the introduction of the TFA.<sup>4</sup>

After the sharp decline in acceptance, the Department of Family Welfare started systematic preparatory work in December 1996 to strengthen the target-free system from 1997-98 onwards. The Secretary of Family Welfare, in his letter dated December 30, 1996, asked the Executive Director of SIFPSA for financial and technical assistance to carry out TFA training in the state. SIFPSA identified the Association for Voluntary Surgical Contraception (AVSC) to provide training. AVSC

developed a facilitator's guide and pilot tested it in the Pindra PHC in Varanasi.<sup>5</sup> Following this, an itinerary for each district was worked out, and facilitators were trained. The facilitators in turn conducted training for three days at block levels and below. The training of all workers was completed by November 1997.

Meanwhile, in a meeting of state secretaries in September 1997, the GOI announced a shift from the target-free to the Community Needs Assessment (CNA) approach. Two workshops were held before this announcement in the National Institute of Health and Family Welfare (NIHFW) to assess the experiences of PHC medical officers from different states in regard to the implementation of TFA. Based on the deliberations in these workshops, the TFA manual was revised and simplified. The new manual tried to address the following: (i) Consultative mechanisms to implement the CNA approach, and (ii) The reporting system and items to be reported. The CNA manual was sent to all the states; Uttar

Pradesh received a copy of it in March 1998. However, no efforts were made to translate the manual or to train health workers. Therefore, the state followed and continued to follow the procedure it had developed in July 1996 to estimate the Expected Levels of Achievement (ELAs), which had replaced targets under the new system.

The Director General of Family Welfare believes that the guidelines from GOI were confusing, so the workers were not clear about their responsibilities. According to him, "Only a small proportion of workers would be conducting surveys actually; the rest of the data are generated at the PHC level. In general, whatever the districts reported has been accepted at the directorate level. Only in the case of five to six districts where the estimation was far off the mark have changes been made at the state level. In actual terms, the system is not working."

## Innovative Activities

The CNA approach offers a unique opportunity to try out innovative activities. The lack of flexible funding and technical support to design innovations are usually the main constraints in their implementation. Thanks, however, to the presence of the USAID-funded Innovations in Family Planning Services (IFPS) Project, implemented by SIFPSA, whereby it has been possible in Uttar Pradesh to develop specific strategies to fulfill the needs of different areas, try them out on a pilot scale, evaluate them, and then replicate them in larger areas after necessary adaptations. Some of the notable innovations tried out are described below.

RCH service delivery through networks of Non-Governmental Organizations (NGOs), milk

The CNA approach offers a unique opportunity to try out innovative activities. The lack of flexible funding and technical support to design innovations are usually the main constraints in their implementation.

<sup>5</sup> "Facilitators Guide for Implementing Target Free Approach" AVSC International, New Delhi, 1996



cooperatives, indigenous medical practitioners, and traditional birth attendants.

Private-sector participation in family planning services was abysmally low in Uttar Pradesh before the launching of the IFPS Project, and there was considerable skepticism about the impact that NGOs could make on the programme. To begin with, SIFPSA, after collecting information from a variety of government and NGOs, prepared a list of NGOs working in the development field. These NGOs were then informed of the funding available for a limited period for innovative family planning projects and were encouraged to submit project proposals. A system was also established to verify the credentials of NGOs and to look at their annual accounts and activities for the preceding three years. The programme officers of SIFPSA visited NGOs seeking funds to check details of the organization, office infrastructure, and the type of activities carried out.

NGO projects generally select women volunteers for community-based distribution (CBD) to promote family planning and MCH services. The main goal of NGO projects is to increase the use of modern spacing methods among young, low-parity couples. CBD volunteers visit all households in their villages at regular intervals and encourage couples to adopt the family planning methods of their choice.

A computerized information system has been designed to monitor the performance of NGOs. At the end of the project, their performance is evaluated by an expert external agency in light of the objectives stated in the project agreement. Based on the findings, a decision is made to extend, expand, or discontinue a project. So far, more than 90 projects

have been funded, and 50 have been evaluated by external agencies.

An evaluation in 15 districts was conducted by an external agency in January 1999, to assess the extent of the increase in the number of spacing method users as a result of SIFPSA-funded private voluntary organization (PVO) projects. As part of this evaluation, 1,300 married women in the age group 13-49 were interviewed. The findings showed that 7.2 per cent were using one of the spacing methods. This is almost double the prevalence rate of 3.7 per cent for these methods recorded in June 1995. This means that the number of spacing method users in these districts increased from 238,000 to 463,000 in the last 3.5 years. Of the total of 225,000 new users, 170,000 had accepted since January 1998. The evaluation concluded by saying, "This shows that family planning services have grown rapidly and SIFPSA-funded projects are contributing significantly to family planning use in Uttar Pradesh."<sup>6</sup> Such projects are operational in 20 districts of Uttar Pradesh and have helped to rapidly increase access to quality services in rural areas.

---

Private-sector participation in family planning services was abysmally low in Uttar Pradesh before the launching of the IFPS Project, and there was considerable skepticism about the impact that NGOs could make on the programme.

---

Village milk cooperatives offer an opportunity to involve large networks of volunteers in the promotion of family planning because they are economic groups with excellent logistics that have almost a million members with a good understanding of rural marketing. Projects funded through the Federation of Milk Cooperatives use village cooperatives to select a woman family welfare promoter from the community. Members of the

<sup>6</sup> "Innovations at Work", SIFPSA, and Unpublished Evaluation Documents of SIFPSA, Lucknow, 1999



milk cooperatives help the volunteers provide family planning services.

Uttar Pradesh has nearly 40,000 registered, indigenous system of medicine (ISM) practitioners, that is, *unani*, *ayurvedic*, and *homeopathic* medical practitioners, and probably an equal number of non-registered practitioners. A large proportion of the rural population seeks health services from ISM practitioners because of their accessibility and low fees. Recognizing the potential of ISM practitioners to improve counselling and access to family planning services, SIFPSA launched two projects on a pilot basis in Sitapur and Jhansi districts to train ISM practitioners. A needs assessment was done, and

training curricula and materials were then developed and tested.

An evaluation of the ISM training programmes was conducted by an external agency in 1997. The findings revealed that not only had the general client load of ISM practitioners increased after training but there had also been a substantial increase in the

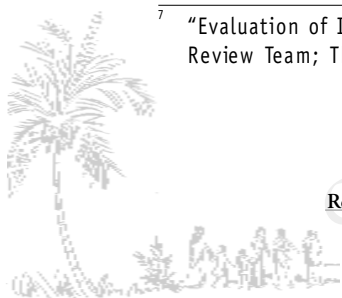
proportion of ISM practitioners providing family planning services to clients. Encouraged by the results, SIFPSA has scaled up activities in the last two years to cover 10 more districts. So far, about 7,000 ISM practitioners have been trained in these districts. The projects not only provide basic training of four days duration to ISM practitioners but also offer re-orientation training after a period of six months. In addition, project staff members visit trained ISM practitioners regularly to observe the counselling sessions, to identify needs for retraining, and to solve problems related to contraceptive supplies.<sup>7</sup>

Traditional Birth Attendants (TBAs) or *dais* have always assisted deliveries, especially in rural areas. One-third of all deliveries taking place in Uttar Pradesh are assisted by TBAs, but a large proportion of dais has never been trained. The practices followed by untrained dais have significantly contributed to neonatal deaths. Recognizing the close relationship between infant mortality and family planning use, SIFPSA has initiated training programmes for untrained dais. Pilot projects have been implemented in Rampur, Sitapur and Agra districts. The objective of these programmes is to encourage dais to conduct deliveries in aseptic conditions, to identify and refer high-risk pregnant women to hospitals and to promote family planning. A complete census was done of dais in all villages of these three districts. Master and lead trainers were trained and, in turn, imparted training to more than 2,000 dais. Each one has been given an identity card and a delivery kit.

An evaluation of SIFPSA-supported training for dais conducted by an external agency in 1999 found the following:

- 98 per cent of dais were providing family planning services to clients
- 53 per cent of dais were able to identify high-risk pregnancies
- 28 per cent of dais were able to answer questions on pill use correctly
- Deliveries assisted by trained dais had increased to nine per cent from three per cent before training

<sup>7</sup> "Evaluation of ISMP Project in Jhansi and Sitapur" Paper presented in a workshop held at Lucknow for the IFPS Mid-term Review Team; The Policy Project, The Futures Group International, New Delhi, 1997



Encouraged by the impressive findings of the evaluation, SIFPSA has begun to expand dais training to 12 more districts in a phased manner.<sup>8</sup> Rural networks of trained ISM practitioners and TBAs are increasing family planning outreach and improving delivery services.

**Decentralized planning and implementation of RCH activities using a mix of public and private sector interventions managed by an autonomous society at the district level**

The planning process for the Reproductive and Child Health (RCH) programme has remained highly centralized, but effective and efficient implementation of programmes aimed at behavioural change require decentralized plans that take into consideration local resources and client needs. Recognizing the need to decentralize RCH at the district level, SIFPSA facilitated the formulation of district action plans (DAPs) in six districts. This pioneering effort was the first of its kind in Uttar Pradesh and perhaps in all of India. Baseline surveys were conducted, information on key indicators was disseminated to all stakeholders in both the public and private sectors, workshops were conducted to identify district-specific issues, and a census of facilities was done to identify gaps. Districts set their own objectives and evolved strategies to achieve them through a decentralized management system. The district action plans were approved in March 1998.

In each district, the local District Innovations in Family Planning Services Agency (DIFPSA) was registered as a society with representatives from the private and public sectors. SIFPSA established Project Management Units at the district level to solve problems at the time of implementation, to disseminate information, and to act as a link between

the public and private sectors. The district action plans include the following five clearly identified strategies:

- Creating a conducive environment
- Generating demand through IEC
- Improving access to integrated services
- Improving quality of services
- Involving the non-governmental sector

The planning teams identified specific activities for each strategy and prepared a time frame for implementation of each.

In the six DAP districts, nearly 800 religious leaders attended the meetings on family planning. Furthermore, 4,500 *Pradhans* attended training programmes, and all workers in the private and public sectors received training in interpersonal counselling. In addition, 792 female health workers received IUD insertion training; 1,128 integrated RCH camps were conducted; 28 innovative PVO and organized sector projects were implemented; and three milk cooperative projects covering a population of 17.9 million were initiated.

At the end of one year of implementation of the district action plans, acceptance of all methods of family planning in both the private and public sectors improved considerably. Sterilization acceptance

---

Recognizing the need to decentralize RCH at the district level, SIFPSA facilitated the formulation of district action plans (DAPs) in six districts. This pioneering effort was the first of its kind in Uttar Pradesh and perhaps in all of India.

---

<sup>8</sup> "Innovations at Work" SIFPSA, and Unpublished Evaluation Document of SIFPSA, Lucknow, 1999



increased by about 20 per cent and spacing services also expanded. Providing integrated services, improving the quality of those services, and increasing access to services have all contributed to the gains in performance in the DAP districts. This model has been found suitable for replication, and SIFSPA, encouraged by the results, has decided to extend the decentralized district action plan approach to six more districts.<sup>9</sup>

### **RCH camps at CHCs and block PHCs**

These camps provide an opportunity to integrate the efforts of providers and to increase access to reproductive health services. Each camp includes a gynaecological check-up, a child examination and immunization, family planning counselling and services, and transportation for sterilization clients. Though sterilization camps have been part of the family planning programme for many years, these RCH camps, which are becoming popular as *Parivar Swasthya Seva Divas*, are different in the following ways:

- They provide assured services as per a pre-determined calendar
- They combine the benefits of rural outreach and high quality services
- They provide an array of MCH and family planning services under one roof.

The organization of camps involves detailed planning of publicity, manpower deployment, camp arrangements, post-camp services like transportation, and the availability of consumables and medical equipment. Each camp is scheduled in advance and publicized through advertisements in local

newspapers. Specially designed banners and handbills promote them as *Parivar Swasthya Seva Divas*. In rural areas, the word is spread by playing attractive jingles on audio-cassettes carried around in hired rickshaws or vehicles. Since most of these camps are in remote rural areas, the availability of a team of surgeons, an anaesthetist and a female gynaecologist must be ensured at the district level. An enhanced budget for maintenance and POL (petrol, oil, and lubricant) for vehicles is provided so that an adequate number can be deployed to transport doctors to RCH campsites and sterilization clients to their homes. SIFPSA has also provided funds for the purchase of bleach, antiseptics, gloves, medicines, and laparoscopes for use in these camps. Deputy chief medical officers monitor the camps as per a standard proforma.

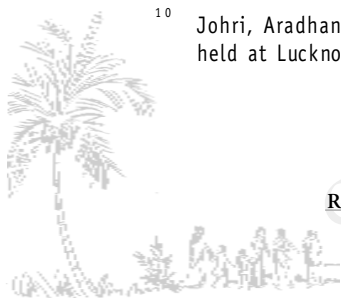
This integrated approach to providing NCH, and family planning services has been found to be more cost-effective and also more convenient for clients. SIFPSA will fund 13,000 of these camps over the two-year period beginning May 1998; 9,000 had been held by December 1999. On an average, 50 clients attend each camp and more than half of them use the integrated MCH services. In many districts, more than 33 per cent of sterilization procedures have been performed in such camps, which indicates their success and popularity. Assured availability of services along with the orientation of Pradhans is also helping to raise community awareness about reproductive health and to mobilize institutional support for services.<sup>10</sup>

### **Tetanus Toxoid Campaign**

The infant mortality rate (IMR) in Uttar Pradesh is 85 per thousand live births, of which about four per

<sup>9</sup> "Making things Happen", The POLICY Project, The Futures Group International, New Delhi, 1999

<sup>10</sup> Johri, Aradhana, "Special Campaigns in Uttar Pradesh," Paper presented in the Uttar Pradesh Population Policy Workshop held at Lucknow, Organized by the GOUP and The POLICY Project, The Futures Group International, New Delhi 2000





cent is estimated to be due to neonatal tetanus. As per the Central Bureau of Health Investigation, Uttar Pradesh accounts for 21 per cent of the total number of neonatal deaths in India. The maternal mortality rate (MMR) is also high at 707 per 100,000 live births. The idea of conducting a tetanus toxoid (TT) campaign to immunize women was suggested by SIFPSA and adopted by the government of Uttar Pradesh. The TT campaign formed the cornerstone of an accelerated strategy for reducing Maternal and Infant Mortality (MIM) in the state.<sup>11</sup>

The following were the steps in the planning process:

- The Principal Secretary of Medicine, Health and Family Welfare of Uttar Pradesh met with SIFPSA on February 5, 1999. The Director General of Family Welfare, his key staff, SIFPSA officers, and additional directors of divisions who endorsed the idea of conducting a TT campaign also attended the meeting. The following decisions were made:
  - The campaign should be organized in 15 SIFPSA districts in two phases, and all pregnant women should be covered
  - A baseline survey should be done in each sub-centre area by the ANMs to get lists of pregnant women
  - The campaign should be run in the plains for a week and for two weeks in the hills
  - The strategies for rural areas and urban areas should be different
  - In urban areas, the support of Indian Medical Association (IMA) and private practitioners would be accepted

- In rural areas, TT vaccinations would be offered for a day at sub-centres and then from door-to-door in villages on the other days
- The campaign would use glass syringes and needles available at PHCs/CHCs/ sub-centres; disposable syringes would not be used
- IEC material should be prepared at the state level with assistance from SIFPSA; messages should focus on the benefit of the campaign for the newborn
- Immunization cards would be available to all pregnant women who receive TT vaccinations
- Meetings should be held at the state and district levels for coordination with other departments. District magistrates should chair district-level meetings.

It was also decided that SIFPSA should provide technical assistance in drawing up schedules, drafting instructions, and working out other details as the campaign was being held for the first time in Uttar Pradesh. The Director General for Family Welfare was asked to assess the availability and adequacy of the vaccine, syringes, and the cold chain.

- SIFPSA, in consultation with the Director General for Family Welfare, developed a TT campaign timetable providing dates by which different meetings should be held at the state, district, and sub-district levels. This timetable included details of participants as well as actions to be taken in the meetings.
- A workshop was organized on March 8, 1999, in which 11 ANMs, seven Lady Health Visitors

<sup>11</sup> "Innovations at Work," SIFPSA, and Strategy Document of TT Campaign, SIFPSA, Lucknow, 1999



(LHVs), two medical officers in charge of PHCs, two deputy chief medical officers, and one senior medical officer (Stores)) were invited. The following items were discussed:

- The timing of the campaign
- The target segment
- The lists of pregnant women for vaccination
- The time of the day during which vaccination services would be provided at booths and door-to-door
- The system for carrying vaccines to the field and receiving supplies from PHCs
- Matters related to reporting
- Logistics on the availability of syringes and needles, ice packs, pressure cooker sterilizers, cotton wool, kerosene, and spirits.

The meeting also identified what materials were readily available and what additional resources were required for the campaign.

- The Principal Secretary for Medical, Health and Family Welfare held another meeting on March 10, 1999, in which senior officers of the Family Welfare Department and SIFPSA participated. The following points were decided at this meeting:
  - All pregnant women throughout the state would be covered under the campaign for TT immunization and the distribution of iron and folic acid (IFA) tablets. Oral Rehydration Salt (ORS) packets would also be made available as needed

- The programme would be initiated from the first week of May 1999 in two phases. The first dose would be provided on May 1, 3, and 5, 1999. The second dose would be provided on June 2, 5, and 7, 1999. An estimated 49 lakh women were likely to be covered in each phase (1 lakh = 100,000)
- The enumeration of pregnant women would be conducted from April 12-17, 1999
- The strategies for rural and urban areas would be different keeping available resources in mind
- The availability of vaccine, cold chain equipment, syringes, and needles would be ensured. “The one syringe, one vaccine, one beneficiary” norm would be followed. Sterilization of syringes and needles would be specially taken care of
- For proper publicity, IEC materials such as handbills, posters, and banners were developed. Wall paintings were also done along with local announcements (*dugdugi*). The distribution of IEC materials would start at the time of enumeration
- The involvement of NGOs, other state government functionaries and elected bodies would be sought to make the campaign more effective
- Efforts would be made to anticipate and meet all logistical requirements.

Details of the campaign were worked out by SIFPSA along with the Department of Family Welfare and were communicated to Chief Medical Officers



(CMOs) and Additional Directors of Divisions vide the Principal Secretary for Medical, Health and Family Welfare of Uttar Pradesh in a letter dated March 26, 1999. These instructions included guidelines for conducting a survey of pregnant women between April 12 and 17, 1999, and for making micro-plans for implementing the campaign in sub-centres, PHCs and districts. Instructions were also included for the medical officer in charge on preparing lists of pregnant women, on IEC activities, on sterilizing syringes and equipment, and on storing and distributing vaccines. The use of immunization cards, forms, reporting proforma, and the system for monitoring and supervision were also highlighted. CMOs were also requested to hold the following two meetings in their districts on specific days:

- A meeting chaired by the District Magistrate to coordinate with representatives of other departments like Integrated Child Development Services (ICDS), the District Urban Development Agency (DUDA), local urban bodies, development departments like education, rural development, Panchayati Raj and NGOs. This meeting would brief them about the strategy and obtain the support of other departments for the TT campaign.
- A meeting of all deputy CMOs and medical officers of CHCs/PHCs to share the scheme with them and assign their responsibilities. As time was short, these medical officers were to develop plans to hold meetings of workers at their CHCs/PHCs and brief them and also assign duties for the campaign including the baseline surveys to be done by ANMs. The CMOs would also obtain feedback from these officers on likely difficulties, district resource requirements and doubts, if any, for clarification from Lucknow (the capital of Uttar Pradesh).
- On April 13, 1999, a meeting of all CMOs was held by the Principal Secretary for Medical, Health and Family Welfare to take stock of the situation and to finalize the allocation of personnel, vaccine, syringes and IEC material to all districts. Detailed monitoring plans were also shared with the officers.
- Senior officers from headquarters of the rank of director and additional director (AD) were deployed for monitoring in each division. They were briefed by the Director General of Family Welfare and were provided with two checklists developed by SIFPSA. They were to use one checklist while the other was to be used for monitoring by medical officers and deputy CMOs in the districts.
- IEC material was developed by SIFPSA. Artwork was distributed to districts for printing handbills and cloth banners. A 10-point informative flier entitled “Ten Important Facts” informing providers and clients about TT was also made available. The handbills were to be used during the baseline survey to educate and inform clients in rural areas and slums about campaign dates. Cloth banners were for informing people about the campaign. Pre-recorded cassettes were also provided to PHCs for publicity a few days before the campaign. TV, radio, and press were used to popularize the campaign including broadcasting messages from the Chief Minister and the Health Minister promoting TT vaccinations. Panel discussions were also held with experts on radio and TV to provide information and to build confidence.

After the first phase of the campaign, the Director General of Family Welfare debriefed observers. On the basis of this and the reports of ADs and CMOs, Principal Secretary for Medical Health and Family



Welfare of Uttar Pradesh held a meeting to incorporate corrections for the second phase.

To evaluate this campaign, the Population Resource Centre (PRC) in Lucknow carried out a coverage survey in five randomly selected districts from five regions of the state. The districts covered were Agra, Allahabad, Almora, Sitapur, and Lalitpur. By using the 30 cluster sampling technique, 1,023 pregnant women from 100 clusters (both urban and rural) of the five selected districts were interviewed. The findings indicate that before the campaign, 31 per cent of pregnant women had received a first dose of TT vaccine and 13 per cent had been fully immunized. After the campaign, an additional 29 per cent of women received a first dose of vaccine while an additional 20 per cent became fully immunized. Thus, at the end of the campaign, 59 per cent of pregnant women had received the first dose of TT and 33 per cent had received at least two doses<sup>12</sup>.

### **Effects of the Community Needs Assessment Approach**

The impact of the adoption of this policy reform in Uttar Pradesh on certain critical areas has been as follows.

### **Community Involvement**

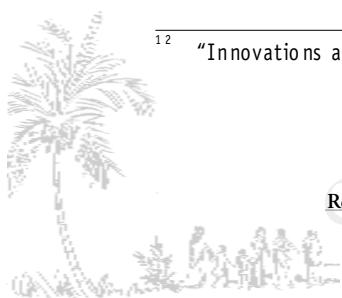
Evidence from the field suggests that the CNA approach has not involved the community in any significant way in the work of the public sector. Decentralization has taken place within government structures only as the state has taken over some of the roles of the national government relating to the issue of guidelines, fixing work loads, etc. Community leaders are also not interested in decentralized planning under CNA as it does not involve the transfer of funds. The training of *Pradhans* in six

districts and their orientation to RCH services by SIFPSA, while increasing their knowledge about their roles, has not resulted in their greater involvement in the programme or in their support for the ANMs.

Programme personnel themselves are also not proactive about the approach as they are afraid to raise community expectations that the programme is not ready to meet. The role of the health workers, however, has increased. They have more autonomy in being able to plan their visits to households for MCH activities. Health functionaries are not, however, interested in involving community leaders in the programme because the leaders have a political agenda. The government of Uttar Pradesh, as part of its decentralization initiative, issued an order on July 9, 1999, placing the services of male Multi-Purpose Workers (MPWs) along with grassroot workers from seven other departments under the supervision and control of *Gram Pradhans*. This was strongly resented both by the workers and by public sector programme managers who have voiced their concerns at several forums.

In the community development blocks of the 15 districts where SIFPSA is implementing its NGO-managed, CBD projects, there is a closer involvement of the community in the RCH programme. These NGOs usually have previous experience working in the development sector and so select women volunteers from within the community for promoting family planning and MCH services. These volunteers visit village households at regular intervals. As members, they can better appreciate the needs of the community and respond to them, which bring the RCH programme closer to the community. The use of NGOs by SIFPSA for planning, monitoring, and facilitating folk performances with health and family planning

<sup>12</sup> "Innovations at Work," SIFPSA, Lucknow, 1999



messages woven into them has further strengthened this linkage. The response of the community to these folk performances has been overwhelming and has also generated demand for making health services available to the villagers.

### **Service Quality**

Removing targets was expected to improve the quality of services. The new monitoring system included a number of quality indicators. While there was no significant improvement in early acceptance of contraception or in continuation rates, the knowledge about modern methods seems to have increased. The Rapid Household Survey of December 1998, has data for all major states. It shows that 74 per cent of women in Uttar Pradesh knew of all modern methods of contraception. Uttar Pradesh thus ranked third after Kerala and Punjab in this indicator showing the availability of informed choice of methods. Further, as per this survey, one-fourth of users were informed about the side effects of the family planning method they had selected. No improvement is discernable, however, in indicators like early prenatal registration or timely immunization of children.<sup>13</sup>

### **Programme Priorities**

Since the adoption of the CNA approach, Uttar Pradesh has focused on MCH services and not on family planning alone. Ante-Natal Care (ANC) and safe deliveries, that is, deliveries assisted by persons trained in midwifery, have emerged as programme priorities. Efforts are also being made to reduce infant and maternal mortality through strategies like the campaign to provide TT vaccinations to pregnant

women. These initiatives helped increase the proportion of women who have received two or more doses during their pregnancies. Similarly, wider expansion of training for TABs under the IFPS Project has resulted in 34 per cent more deliveries attended by trained providers.<sup>14</sup> The IFA coverage for pregnant women has also gone up by 10 per cent according to the 1999 National Family Health Survey (NFHS-2) results.<sup>15</sup>

The timely immunization of children has also received special attention. The government of Uttar Pradesh has increased the number of "immunization days" from one to two per week. Now, every Wednesday and Saturday (instead of only Wednesday) the ANM has to be present in her service area to provide routine immunization services for all preventable diseases. In addition, Uttar Pradesh is following the pulse polio immunization schedule with three national immunization days (NIDs) and three sub-NIDs for extended reach and coverage of resistant groups. However, this does not seem to have had a major impact. The total immunization rate remained constant at 20 per cent from 1993 to 1999. However, there has been some improvement in the immunization status for BCG and measles, and at least one immunization service has reached 71 per cent of children, a 24 per cent increase over the 1992-93 level.<sup>16</sup>

### **Worker's Status in the Community**

Various studies have shown that workers reported positive images of themselves and of the programme because they were talking more about the mother's and children's health and less about family planning.

<sup>13</sup> Rapid Household Survey: India, International Institute for Population Sciences, Mumbai, and MOHFW, GOI, New Delhi, 1999.

<sup>14</sup> "Innovations at Work," SIFPSA, and Unpublished Study Report on TBA's, SIFPSA, Lucknow, 1999

<sup>15</sup> National Family Health Survey (Preliminary Report): Madhya Pradesh, International Institute for Population Sciences, Mumbai, 1999

<sup>16</sup> National Family Health Survey (Preliminary Report): Madhya Pradesh, International Institute for Population Sciences, Mumbai, 1999.



They were also providing comprehensive health care that included immunizations, antenatal check-ups, household visits, and family planning counselling. The views expressed by workers in this context are eloquent. One worker remarked, “The pressure of targets is no longer there and we are able to plan our work better. We cater to the problems of women and children and can visit villages more often. Our acceptability in the community has also increased.”

The self-esteem of workers also increased on two counts. In the earlier system, the vigorous monitoring of sterilization targets at the PHC and district levels along with threats of punishment and the guilt associated with non-achievement of targets made them feel inadequate and demoralized them. Under CNA, they feel that the monitoring system is a better measure of their overall performance. Secondly, before CNA, ANMs were unable to screen or counsel clients. However, after undergoing clinical and counselling training, their skills have improved. Training has also been helpful in changing the attitudes of workers and in equipping them to a certain extent with the ability to discuss clients’ needs and offer services according to clients’ choices and preferences.

### Clients’ Perceptions about Services

Reduced emphasis on sterilization has resulted in greater availability of spacing methods and of MCH

services. The dependence on the public sector for IUDs increased by 11 percentage points in 1998-99 compared to 1992-93 showing that the training of ANMs, their improved skills and the time they are able to devote to counselling has made them better accepted as providers of IUDs.

### Family Planning Performance under the New Approach

Acceptance of family planning methods declined in the first year after the adoption of the TFA. Thereafter, sterilization acceptance improved but has still not reached pre-TFA levels. The use of spacing methods, however, has increased by 11 percentage points (i.e., from 34-45 per cent) in the last six years. Further, the role of the private sector as a provider of spacing methods (condoms and pills) has grown significantly as three-fourths of all condom-users got their supplies from the private sector in 1998-99 compared to 57 per cent in 1992-93. Likewise, over 70 per cent of all pill-users depend on the private sector today as compared to 48 per cent six years ago. This is an indication that SIFPSA-supported, NGO, community-based distribution workers, alongwith interventions in the commercial sector, are having an impact by improving accessibility to condoms and pills. <sup>15</sup>

### Sterilization

The number of acceptors of sterilization in 1994-95 was 516,970, and in the following year it

Table 1  
Total Users of Spacing Methods Reported by Service Statistics in Uttar Pradesh, 1994-99

Year	Method		
	IUD	Oral Pills	Condoms
1994-95	2,194,522	487,250	2,897,773
1995-96	2,193,488	558,509	2,434,224
1996-97	1,664,021	514,525	1,769,096
1997-98	2,029,847	764,044	2,045,682
1998-99	2,084,468	722,290	1,923,835



increased to 519,399. Allahabad, Faizabad, Garhwal, Jhansi, and Kumaun divisions performed better while the remaining nine divisions did not. With the introduction of the TFA in the state in 1996-97, only 266,350 sterilization operations were conducted, a decline of 95 per cent from 1995-96 levels. Surprisingly, all divisions in the state, including the five divisions that had performed well in 1995-96 indicated poor performance. It should be noted that two districts each in Varanasi and Gorakhpur became part of the newly created Azamgarh division and hence their performance in 1995-96 declined. In 1997-98, however, performance started to improve, and in 1998-99 acceptance was up by 14 per cent over the previous year. Still, when compared with 1994-95, overall performance was down by 49 per cent.

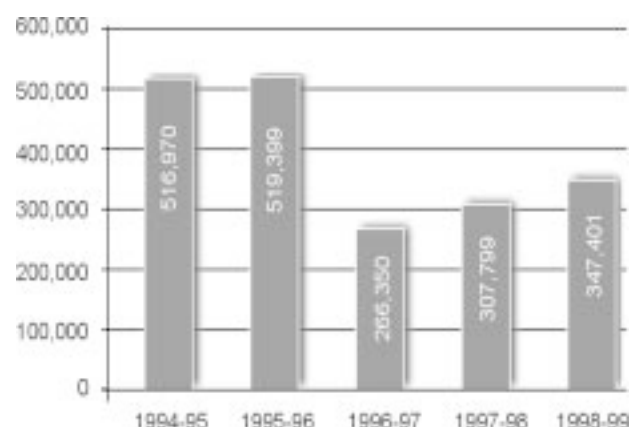
On the whole, it can be deduced that due to the introduction of the TFA in the state, sterilization performance dropped substantially. All divisions that had performed well during the period prior to the TFA performed below expectations. Nevertheless, a close examination of trends from 1997-1999 indicate that sterilization acceptance is likely to improve in the coming years as all divisions have started performing more operations than in the previous year. Even though information on age and parity of new acceptors was available in the management information system formats, no effort was made to analyze the data either at the district or state levels. Analysis of this type will provide insights in understanding the impact of the programme on fertility.

## Spacing Methods

### IUDs

In 1994-95, as many as 2,194,522 new acceptors of IUDs were recruited while in the subsequent year 2,193,488 insertions were done. In the two years following the introduction of TFA, the programme

Fig.1  
Total Sterilizations Performed in UP



registered 1,664,021 and 2,029,847 new acceptors, respectively. When 1996-97 is compared with 1995-96, acceptance dropped by a third and all divisions performed badly. However, in 1997-98 and 1998-99, the number of acceptors increased substantially and reached 95 per cent of the 1994-95 total. As observed in the case of sterilization, no efforts are being made to analyze the characteristics of new acceptors.

### Oral Pills

The common practice for setting the target for oral pills is in terms of the number-users, but performance records at the district level and below provides information on the number of cycles distributed. That number is aggregated at the state level and divided by 13 to get the total number of users. Following this procedure, vital information on continuing users, dropout rates, and so on that could be analyzed through the monitoring formats is usually overlooked. Consequently, the calculations are restricted to numerical achievements without considering quality issues.

The number of pill-users in the state was 487,250 in 1994-95; in 1995-96, it was 558,509. Unlike the performance in sterilization and IUD, the number of



pill acceptors increased by 15 per cent. In 1996-97, only 514,525 new users were registered, a drop of eight per cent. All divisions except Agra reported poor performance. In 1997-98, acceptance improved in almost all divisions and interestingly, the total was higher than that in 1995-96. In 1998-99, acceptors were fewer in number than in 1997-98, but on the whole pill use was up by 33 per cent from 1994-95. Except for a negligible drop in 1995-96, Agra performed consistently well throughout the reference period, even in the first year of TFA.

Pill acceptance largely depends on supply, and supply is not necessarily driven by demand. An analysis of stock data in Varanasi revealed that the distribution of pills from the state fluctuated considerably. For instance, supplies from the state to our sample districts in 1996-97 fluctuated from a minimum of 10,000 cycles to a maximum of 60,000 cycles per month, and the quantity increased in the last quarter of the fiscal year. In Varanasi in 1996-97, 1,200 cycles were distributed on average each month though it varied from 400 to 6,000 cycles. Moreover, until mid-June 1996, Varanasi did not get any supplies and hence did not distribute any. After receiving stock, it supplied 400 cycles to the PHC in Pindra in the same month. In the following month, the district received 24,000 cycles and it supplied 1,500 cycles to Pindra. Towards the last quarter of the fiscal year, the average supply was over 2,000 cycles per month. Given these variations in distribution, the methodology for calculating users is questionable. Reported figures are likely to be inflated rather than based on actual use. The lack of information on continuous users is a major constraint to reaching any conclusions on the actual number of users of oral contraceptives.

### **Condoms**

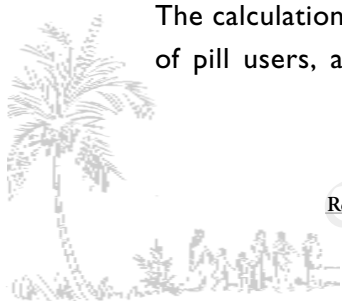
The calculation of condom-users is similar to that of pill users, and identical problems exist. The

reported number of condoms distributed is divided by 72 to get the number of acceptors. In 1994-95, there were 2,897,773 condom-users; the number decreased to 2,434,224 in 1995-96, a decline of 16 per cent. The decrease was highest in Kumaun division while Moradabad and Allahabad registered increases. The downward trend in acceptance continued in the following year with the exception of Kanpur. The decline in acceptance in 1996-97 compared to the previous year was 27 per cent. The trend continued until acceptance in 1998-99 was over one-third of what it had been in 1994-95.

The quantity of condoms distributed from the state to the districts and from districts to other centres varied from month to month. For instance, Varanasi distributed 18,000 condoms in the beginning of April 1996 though 468,000 had been received by the end of the month. Varanasi did not supply any condoms to the PHC in Pindra until the end of this quarter although it had received over 700,000. Once again, this fluctuation reinforces the fact that the condom use is supply driven; generally, higher performance was reported when supplies were abundantly available and lower performance was reported when they were not.

### **Workers' Responses to the Target-Free Approach**

Health workers from Varanasi, the PHC in Pindra, and two sub-centres were interviewed about the CNA approach. Their responses were mixed. All senior officials at the district level shared a basic understanding of the approach. While some of the medical officers had a detailed knowledge about different aspects of it, others were unable to elaborate on their understanding. Nevertheless, many senior officials felt that the changes introduced had already improved the quality of services though they could not provide specific examples. One senior





official remarked, “The impact of the target-free approach has been very good, there is good cooperation at the grassroot level...they have started doing good work, the quality of work has improved.”

The optimism expressed by some of the senior officials was tempered by the reservations expressed by others. These officials felt that to succeed, the new approach required sincerity and dedication. Over the years, the lower-level workers have become conditioned to working with fixed targets and to feeling compelled to achieve them. Further, they perceived that the level of dedication required to work in the new environment was not there. One official remarked, “They will not work without a stick behind them. In the case of target-free, they become lazy. They think there is no need to go to the field because there is no target, but if there is pressure on the person to meet the target, irrespective of whether they are able to achieve 100 per cent of the target or just 50 per cent, the effort will be there. But in the target-free environment, the workers feel that it is enough if they provide the method when clients approach on their own.”

It is not too difficult to comprehend the reservations expressed by some of the medical officers and district officials, if we consider how field workers responded to the new approach. The senior officials explained that the new approach was welcomed by the field workers, ANMs, and to some extent by the health supervisors with great enthusiasm. The responses of the field workers we met in the study corroborated the views put forward by the senior officials. Almost all the ANMs mentioned that their initial response to the transition to TFA was one of sheer relief and happiness. Further probing elicited that this reaction was based on an erroneous understanding of the concept. The lower-level workers gathered from the name of the approach that they were virtually free from targets. In other

words, the name turned out to be a misnomer that created a lot of confusion.

This understanding remained etched in their minds until they were trained in the new approach. After that, their initial understanding underwent a vast change, and one of the functionaries interviewed offered the following comments: “Initially we were very happy when we were told about the target-free approach. Virtually there were no targets for sterilization and this reduced the tension. But after we underwent the orientation and the methodology of working out the activity plan, we feel that it is nothing but an old wine in new bottle.”

The impression we received throughout our discussions was of a lack of clarity, particularly in making activity plans. In fact, the concept of activity plans seemed to be almost alien to at least some of the workers. This is probably because the implementation of TFA was not supplemented by the required logistic support and training, and that hindered a smooth transition. The necessary registers and reports were not available in printed form, so handmade copies were used, thus adding to the already existing confusion. Some of the lower-level workers reported that they had problems in filling out the forms given to them. They also seemed to resent some of the detailed paper work required of them.

When questioned closely, the official in charge explained that the programme was still in a transitional stage. This being the case, not all the activities specified in the manual were operational. According to him, the fundamental weakness of the programme was related to the way the targets were fixed. Ideally, the targets and activity plans were to be solely based on the needs of the community, but this was not always practical because a specified quota of targets had to be maintained. In effect, as one official



explained, “The activity plans were made based on a standard formula given by the Directorate. By applying the formula to the population, targets are worked out. Therefore, the current system followed can be described as a combination of a targeted and target-free approach.”

In short, community needs were either not considered or were given marginal importance in arriving at the ELAs. Many of the workers who felt that TFA was good stated that it would be so in terms of daily functions only when community needs were taken into consideration. The following quote is illustrative: “If TFA or CNA, the way it is called now, is paid attention and done properly, then it is a very good one. The client-centred activities should be done by the ANM properly after surveying and satisfying the clients in reality...and no work should be done in the air. Unless and until they have authentic information about client needs, then the

TFA will be successful or else there will not be any difference between the TFA and the earlier one.”

Overall, the present status is that workers are clearer about the concept as well as the workings of TFA. They did try estimating ELAs for each of the indicators given in the activity plans using the EC survey. However, after submitting the plans to the district, corrections were made and the ELAs were revised. Off the record, some senior officials expressed their disillusionment with the system. They mentioned that with the introduction of the new approach, their efforts had been directed at getting workers to function according to the guidelines. Now that things were falling into place, targets were being imposed on them again. The ELAs approved by the district were always higher than those sent from the PHC. This had resulted in not just a waste of effort by the workers but had led to confusion and disillusionment as well.

